CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2019	**Date: August 6, 2010**
	Change Request 7089

SUBJECT: Claim Adjustment Reason Code (CARC), Remittance Advice Remark Code (RARC), and Medicare Remit Easy Print (MREP) Update.

I. SUMMARY OF CHANGES: This Change Request (CR) instructs contractors to add or modify reason and remark codes that have been added or modified since CR 6901. This CR also instructs Shared System Maintainers (SSMs) to deactivate the codes that have been deactivated since CR 6901, and instructs SSMs and CEDI to accept deactivated codes in derivative messages. Additionally this CR instructs Viable Information Processing Systems (VIPs) to update Medicare Remit Easy Print (MREP).

EFFECTIVE DATE: October 1, 2010
IMPLEMENTATION DATE: October 4, 2010

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Recurring Update Notification

**Unless otherwise specified, the effective date is the date of service.*

Attachment – Recurring Update Notification

Pub. 100-04	Transmittal: 2019	Date: August 6, 2010	Change Request: 7089

SUBJECT: Claim Adjustment Reason Code (CARC), Remittance Advice Remark Code (RARC), and Medicare Remit Easy Print (MREP) Update.

Effective Date: **October 1, 2010**

Implementation Date: October 4, 2010

I. GENERAL INFORMATION

A Background: The Health Insurance Portability and Accountability Act (HIPAA) of 1996 instructs health plans to be able to conduct standard electronic transactions adopted under HIPAA using valid standard codes. Medicare policy states that Claim Adjustment Reason Codes (CARCs) are required in the remittance advice and coordination of benefits transactions. Medicare policy further states that appropriate Remittance Advice Remark Codes (RARCs) that provide either supplemental explanation for a monetary adjustment or policy information that generally applies to the monetary adjustment are required in the remittance advice transaction.

The CARC and RARC changes that impact Medicare are usually requested by CMS staff in conjunction with a policy change. Contractors and Shared System Maintainers (SSMs) are notified about these changes in the corresponding instructions from the specific CMS component which implements the policy change, in addition to the regular code update notification. If a modification has been initiated by an entity other than CMS for a code currently used by Medicare, contractors must either use the modified code or another code if the modification makes the modified code inappropriate to explain the specific reason for adjustment. **SSMs have the responsibility to implement code deactivation making sure that any deactivated code is not used in original business messages, but the deactivated code in derivative messages is allowed. SSMs must make sure that Medicare does not report any deactivated code on or before the effective date for deactivation as posted at the WPC Web site.** Contractors shall stop using codes that have been deactivated on or **before** the effective date specified in the comment section (as posted on the WPC Web site) if they are currently being used In order to comply with any deactivation, Medicare may have to stop using the deactivated code in original business messages **before** the actual "Stop Date" posted on WPC Web site because the code list is updated 3 times a year and may not align with the Medicare release schedule. Note that a deactivated code used in derivative messages must be accepted even after the code is deactivated if the deactivated code was used before the deactivation date by a payer who adjudicated the claim before Medicare. Medicare contractors must stop using any deactivated reason and/or remark code past the deactivation date whether the deactivation is requested by Medicare or any other entity. **The regular code update CR will establish the implementation date for all modifications, deactivations, and any new code for Medicare contractors and the SSMs. If another specific CR has been issued by another CMS component with a different implementation date, the earlier of the two dates will apply for Medicare implementation**. This recurring CR lists only the changes that have been approved since the last code update CR (CR 6901 Transmittal 1950), and does not provide a complete list of codes in these 2 code sets. You must get the complete list for both CARC and RARC from the WPC web site that is updated 3 times a year – around March 1, July 1, and November 1 – to get the comprehensive lists for both code sets, but the implementation date for any new or modified or deactivated code for Medicare contractors is established by this recurring code update CR published 3 or 4 times a year according to the Medicare release schedule (see above for exception).

WPC Web site address:

http://www.wpc-edi.com/Codes

The WPC Web site has 4 listings available for both CARC and RARC:

All: All codes including deactivated and to be deactivated codes are included in this listing.
To Be Deactivated: Only codes to be deactivated at a future date are included in this listing.
Deactivated: Only codes with prior deactivation effective date are included in this listing.
Current: Only currently valid codes are included in this listing.

NOTE: In case of any discrepancy in the code text as posted at WPC Web site and as reported in any CR, the WPC version should be implemented.

Claim Adjustment Reason Code (CARC):
A national code maintenance committee maintains the health care Claim Adjustment Reason Codes (CARCs). The Committee meets at the beginning of each X12 trimester meeting (January/February, June and September/October) and makes decisions about additions, modifications, and retirement of existing reason codes. The updated list is posted 3 times a year around early March, July, and November. To access the list go to:
http://www wpc-edi.com/Codes

The new codes usually become effective when published unless mentioned otherwise . Any modification or deactivation becomes effective on the next quarterly release date (April 1 or July 1 or October 1 or January 1) or later to provide lead time for implementing necessary programming changes. Exception: The effective date for a modification may be as early as the approval or publication date if the requester can provide enough justification to have the modification become effective earlier than the next quarterly release date. A health plan may decide to implement a code deactivation before the actual effective date posted at WPC Web site as long as the deactivated code is allowed to come in on COB claims if the previous payer has used that code prior to the deactivation date. In most cases Medicare will stop using a deactivated code before the deactivation becomes effective per the WPC Web site to accommodate the Medicare release schedule.

The following new Claim Adjustment Reason Codes were approved by the Code Committee in June, and must be implemented, if appropriate, by October 4, 2010.

New Codes – CARC:

Code	Current Narrative	Effective Date per WPC Posting
235	Sales Tax .	6/6/2010

Modified Codes – CARC:

NONE

Deactivated Codes – CARC:

NONE

Remittance Advice Remark Codes:

CMS is the national maintainer of the remittance advice remark code list. This code list is used by reference in the ASC X12 N transaction 835 (Health Care Claim Payment/Advice) version 004010A1 Implementation Guide (IG). Under HIPAA, all payers, including Medicare, have to use reason and remark codes approved by X12 recognized code set maintainers instead of proprietary codes to explain any adjustment in the claim payment. CMS as the X12 recognized maintainer of RARCs receives requests from Medicare and non-Medicare entities for new codes and modification/deactivation of existing codes. Additions, deletions, and modifications to the code list resulting from non-Medicare requests may or may not impact Medicare. Remark and reason code changes that impact Medicare are usually requested by CMS staff in conjunction with a policy change. Contractors are notified about these changes in the corresponding instructions from the specific CMS component which implements the policy change, in addition to the regular code update notification. If a modification has been initiated by an entity other than CMS for a code currently used by Medicare, contractors shall use the modified code even though the modification was not initiated by Medicare. Shared System Maintainers have the responsibility to implement code (both CARC and RARC) deactivation making sure that any deactivated code is not used in original business messages, but the deactivated code in derivative messages is allowed. **Contractors must stop using codes that have been deactivated on or before the effective date specified in the comment section (as posted on the WPC Web site) if they are currently being used. Medicare contractors are not to use any deactivated reason and/or remark code past the deactivation date whether the deactivation is requested by Medicare or any other entity.** The complete list of remark codes is available at:
http://www.wpc-edi.com/Codes

RARC list is updated 3 times a year – in early March, July, and November although the RARC Committee meets every month. The RARC Committee has established the following schedule:

Request received in October – January:
Published in early March.
Deactivation becomes effective in October
Any new code or modification become effective when published

Request received in February – May:
Published in early July
Deactivation becomes effective in January
Any new code or modification become effective when published

Request received in June – September:
Published in early November
Deactivation becomes effective in April
Any new code or any modification becomes effective when published

As mentioned earlier, specific CMS components may publish CRs in addition to the recurring code update CRs instructing contractors to use specific RARCs and establishing implementation date that may differ from the implementation date mentioned in the recurring code update CR. If there is any difference in the implementation dates, the contractors are to implement on the earlier of the two dates.

By October 4, 2010 contractors must complete entry of all applicable code text changes and new codes, and the SSMs shall implement all code deactivations. Contractors must use the latest approved and valid Remittance Advice Remark codes in the 835 and corresponding Standard Paper Remittance (SPR) advice.

NOTE: Some remark codes may only provide general information that may not necessarily supplement the specific explanation provided through a reason code and in some cases another/other remark code(s) for a monetary adjustment. Codes that are "Informational" will have "Alert" in the text to identify them as informational rather than explanatory codes. These "Informational" codes may be used without any specific monetary adjustment and an associated CARC explaining that adjustment. **These informational codes should be used only if specific information about adjudication (like appeal rights) needs to be communicated but not as default codes when a RARC is required with CARCs -16, 96, 125, 148, 226, 227, 234, A1, and D23.**

New Codes – RARC:

Code	Current Narrative	Medicare Initiated
N533	Services performed in an Indian Health Services facility under a self-insured tribal Group Health Plan.	NO
N534	This is an individual policy, the employer does not participate in plan sponsorship.	NO
N535	Payment is adjusted when procedure is performed in this place of service based on the submitted procedure code and place of service.	YES
N536	We are not changing the prior payer's determination of patient responsibility, which you may collect, as this service is not covered by us.	NO
N537	We have examined claims history and no records of the services have been found.	NO
N538	A facility is responsible for payment to outside providers who furnish these services/supplies/drugs to its patients/residents.	NO
N539	Alert: We processed appeals/waiver requests on your behalf and that request has been denied.	NO

Modified Codes – RARC:

Code	Modified Narrative	Medicare Initiated
N104	This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS website at www.cms.gov.	YES
N115	This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd, or if you do not have web access, you may contact the contractor to request a copy of the LCD.	YES
N386	This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.	YES
N528	Patient is entitled to benefits for Institutional Services only.	NO
N529	Patient is entitled to benefits for Professional Services only.	NO

N530	Not Qualified for Recovery based on enrollment information.	NO

Deactivated Codes – RARC

Code	Current Narrative	Note
M118	Letter to follow containing further information.	Consider using N202
MA101	A Skilled Nursing Facility (SNF) is responsible for payment of outside providers who furnish these services/supplies to residents.	Consider using N538
N201	A mental health facility is responsible for payment of outside providers who furnish these services/supplies to residents.	Consider using N538
N514	Consult plan benefit documents/guidelines for information about restrictions for this service.	Consider using N130

B. Policy: For transaction 835 (Health Care Claim Payment/Advice) and standard paper remittance advice, there are two code sets – Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) – that must be used to report payment adjustments, appeal rights, and related information. Additionally, for transaction 837 COB, CARC must be used. These code sets are updated 3 times a year on a regular basis. Medicare contractors must report only currently valid codes in both the remittance advice and COB Claim transaction, and must allow deactivated CARC and RARC in derivative messages when certain conditions are met (see BR segment for explanation of conditions). Shared System Maintainers and contractors must make the necessary changes on a regular basis as per this recurring code update CR or the specific CR that describes the change in policy that resulted in the code change requested by Medicare. Any modification and/or deactivation will be implemented by Medicare even when the modification and/or the deactivation have not been initiated by Medicare.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
7089.1	A/B MACs, carriers, DME MACs, FIs, and RHHIs shall update reason and remark codes that have been modified and apply to Medicare by October 4, 2010.	X	X	X	X	X					
7089.2	A/B MACs, carriers, DME MACs, FIs, and RHHIs shall update reason and remark codes to include new codes that apply to Medicare by October 4, 2010.	X	X	X	X	X					
7089.3	FISS, MCS, and VIPs shall make necessary programming						X	X	X		

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
	changes so that no deactivated reason and remark code is reported in the remittance advice and no deactivated reason code is reported in the COB claim by October 4, 2010.										
7089.4	FISS, MCS, VIPs shall update any crosswalk between the standard reason and remark codes and the shared system internal codes provided to the contractors and make any deactivated standard code unavailable for use by the contractors by October 4, 2010.						X	X	X		
7089.5	FISS, MCS, and CEDI shall make necessary programming changes so that deactivated reason and remark codes are allowed in derivative messages after the deactivation implementation date per this CR or as posted on the WPC web site when: ● Medicare is not primary; and ● the COB claim is received after the deactivation effective date; and ● the date in DTP03 in Loop 2430 or 2330B in COB 837 transaction is less than the deactivation effective date as posted on the WPC web site.						X	X			CEDI
7089.6	FISS, MCS, and VIPs shall make necessary programming changes so that deactivated reason and remark codes are allowed in derivative messages even after the deactivation implementation date in a Reversal and Correction situation when a value of 22 in CLP02 identifies the claim to be a corrected claim.						X	X	X		
7089.7	VIPs shall update the Medicare Remit Easy Print (MREP) software to include the most current CARC and RARC lists available from the following Web site: http://www.wpc-edi.com/codes (Note: This update is provided in a separate file since April, 2008.)								X		
7089.8	A/B MACs, carriers, and CEDI for DME MACs shall notify the users that the code update file must be downloaded to be used in conjunction with the updated MREP software.	X			X						CEDI

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
7089.9	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X	X	X					CEDI

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below: N/A

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Sumita Sen at sumita.sen@cms.hhs.gov or 410-786-5755

Post-Implementation Contact(s): Sumita Sen at sumita.sen@cms.hhs.gov or 410-786-5755

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs)*:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.