CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2131	**Date: January 7, 2011**
	Change Request 7250

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 the contractors to update Claim Adjustment Reason (CARC)and Remittance Advice Remark Codes (RARC) reported on the Remittance Advice (RA). It also instructs VMS to update Medicare Remit Easy Print (MREP) software

EFFECTIVE DATE: April 1, 2011
IMPLEMENTATION DATE: April 4, 2011

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.

Pub. 100-04	Transmittal: 2131	Date: January 7, 2011	Change Request: 7250

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

Effective Date: April 1, 2011

Implementation Date: April 4, 2011

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 shall 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 shall make sure that Medicare does not report any deactivated code on or before the effective date for deactivation as posted on 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 shall 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 shall 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 7089 Transmittal 2019), and does not provide a complete list of codes in these 2 code sets. You shall 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 I: In case of any discrepancy in the code text as posted on WPC Web site and as reported in any CR, the WPC version should be implemented.

NOTE II: This recurring Code Update CR only lists the changes approved since the last recurring Code Update CR **once.** If any modification becomes effective at a future date, contractors shall make sure that they update on the quarterly release date that matches the effective date as posted on the WPC Web site. (CMS is currently looking at options available to make sure that modifications are always implemented on the effective date as posted on the WPC Web site)

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 approved 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 on 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 November, and shall be implemented, if appropriate, by April 4, 2011.

New Codes – CARC:

Code	Current Narrative	Effective Date Per WPC Posting
W2	Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies, use only if no other code is applicable. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation only.	10/17/10

Modified Codes – CARC:

Code	Modified Narrative	Effective Date Per WPC Posting
191	Not a work related injury/illness and thus not the liability of the workers' compensation carrier. This change effective 7/1/2011: Not a work related injury/illness and thus not the liability of the workers' compensation carrier Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).	10/17/10
214	Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment. (Note: To be used for Workers' Compensation only) This change effective 7/1/2011: Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation only	10/17/10
218	Based on entitlement to benefits (Note: To be used for Workers' Compensation only) This change effective 7/1/2011: Based on entitlement to benefits. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110	10/17/10

	Service Payment information REF). To be used for Workers' Compensation only	
219	Based on extent of injury (Note: To be used for Workers' Compensation only) This change effective 7/1/2011: Based on extent of injury. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).	10/17/10
221	Workers' Compensation claim is under investigation. (Note: To be used for Workers' Compensation only. Claim pending final resolution). This change effective 7/1/2011: Workers' Compensation claim is under investigation. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).	10/17/10
W1	Workers Compensation State Fee Schedule Adjustment. This change effective 7/1/2011: Workers' compensation jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).	10/17/10

Deactivated Codes – CARC:

Code	Current Narrative	Effective Date Per WPC Posting
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 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. 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 July
Any new code or any modification becomes effective when published

This recurring CR is published four times a year. Codes are updated three times a year, April, July and October as part of this recurring CR. The fourth publication in January is used to add MREP enhancements.

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 April 4, 2011, contractors shall complete entry of all applicable code text changes and new codes, and the SSMs shall implement all code deactivations. Contractors shall 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 a CARC e.g., 16, 96, 125, 129, 148, 226, 227, 234, A1, and D23.**

New Codes – RARC:

Code	Current Narrative	Medicare Initiated
N540	Payment adjusted based on the interrupted stay policy.	Yes
N541	Mismatch between the submitted insurance type code and the information stored in our system.	Yes

Modified Codes – RARC:

Code	Modified Narrative	Medicare Initiated
M25	The information furnished does not substantiate the need for this level of service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this level of service, or if you notified the patient in writing in advance that we would not pay for this level of service and he/she agreed in writing to pay, ask us to review your claim within 120 days of the date of this notice. If you do not request an appeal, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her in excess of any deductible and coinsurance amounts. We will recover the reimbursement from you as an overpayment.	No

Deactivated Codes – RARC:

Code	Current Narrative	Note
None		

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 shall be used to report payment adjustments, appeal rights, and related information. Additionally, for transaction 837 COB, CARC shall be used. These code sets are updated 3 times a year on a regular basis. Medicare contractors shall report only currently valid codes in both the remittance advice and COB Claim transaction, and shall 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 shall make the necessary changes on a regular basis as per this recurring code update CR and/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 has 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	
7250.1	A/B MACs, carriers, DME MACs, FIs and RHHIs shall update reason and remark codes that have been modified and apply to Medicare by April 4, 2011. Note: Some modifications may become effective at a future date. Contractors shall make sure that modifications are implemented on the effective date (which would be later than April 4, 2011) as posted on the WPC Web site for those code modifications.	X	X	X	X	X					
7250.2	A/B MACs, carriers, DME MACs, FIs and RHHIs shall update reason and remark codes to include new codes that apply to Medicare by April 4, 2011.	X	X	X	X	X					
7250.3	FISS, MCS, and VIPs shall make necessary programming 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 April 4, 2011.						X	X	X		
7250.4	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 contractor by April 4, 2011.						X	X	X		
7250.5	FISS, MCS, 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; • The COB claims 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

Number	Requirement	Responsibility									
		A / B MAC	D M E MAC	F I	C A R R I E R	R H H I	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
7250.6	FISS, MCS, and VIPs shall make necessary programming changes so that deactivated reason and remark codes are allowed 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		
7250.7	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		
7250.8	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	D M E MAC	F I	C A R R I E R	R H H I	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
7250.9	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						CEDI

IV.   SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

X-Ref Requirement Number	Recommendations or other supporting information:
N/A	

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Sumita Sen at sumita.sen@cms.hhs.gov or 410-786-5755
Pre-Implementation Contact(s): Angie Bartlett at angie.bartlett@cms.hhs.gov or 410-786-2865

Post-Implementation Contact(s): Sumita Sen at sumita.sen@cms.hhs.gov or 410-786-5755
Post- Implementation Contact(s): Angie Bartlett at angie.bartlett@cms.hhs.gov or 410-786-2865

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.