CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2776	**Date: August 30, 2013**
	Change Request 8422

SUBJECT: Remittance Advice Remark and Claims Adjustment Reason Code and Medicare Remit Easy Print and PC Print Update

I. SUMMARY OF CHANGES:
This CR updates the Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) lists and also instructs VIPs and FISS to update Medicare Remit Easy Print (MREP) and PC Print. This Recurring Update Notification applies to chapter 22, sections 40.5, 60.1, and 60.2.

EFFECTIVE DATE: October 1, 2013
IMPLEMENTATION DATE: October 7, 2013

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; Contractors activities are to be carried out with 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 obliged 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: 2776	Date: August 30, 2013	Change Request: 8422

SUBJECT: Remittance Advice Remark and Claims Adjustment Reason Code and Medicare Remit Easy Print and PC Print Update

EFFECTIVE DATE: October 1, 2013
IMPLEMENTATION DATE: October 7, 2013

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) and 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 and coordination of benefits transactions.

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 that 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 on the WPC Web site.** If any new or modified code has an effective date past the implementation date specified in this CR, contractors must implement on the date specified on the WPC Web site.

The discrepancy between the dates may arise because the WPC Web site gets updated only 3 times a year and may not match the CMS release schedule. This recurring CR lists only the changes that have been approved since the last code update CR (CR 8281, Transmittal 2686, issued on April 12, 2013), and does not provide a complete list of codes for these two code sets. The MACs and the SSMs must get the complete list for both CARC and RARC from the WPC Web site that is updated three times a year – around March 1, July 1, and November 1 – to get the comprehensive lists for both code sets. The implementation date for any new or modified or deactivated code for Medicare contractors is established by this recurring code update CR published three times a year according to the Medicare release schedule and/or specific CR from a CMS component implementing a policy change that impacts Remittance Advice code use.

WPC Web site address:**http://www.wpc-edi.com/Reference**

The WPC Web site has four listings available for both CARC and RARC.

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 lists only the changes approved since the last recurring Code Update CR **once.** If any modification or deactivation becomes effective at a future date, contractors must make sure that they update on the effective date or the quarterly release date that matches the effective date

as posted on the WPC Web site.

NOTE III: The January recurring code update CR is assigned for MREP enhancements, and a log for requests/suggestions is created by VIPs. CMS reviews the log and prioritizes the requests. In order to follow the CMS release schedule, the cut off dates are May 15 for VIPs to receive requests, and July 15 for VIPs to develop and send the log to CMS.

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 along with Group Code to report payment adjustments and Informational RARCs to report appeal rights, and other adjudication related information. If there is any adjustment, the appropriate Group Code must be reported. Additionally, for transaction 837 COB, CARC and RARC must be used. CARC and RARC code sets are updated three 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 Business Requirements 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 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

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
8422.1	Contractors shall update reason and remark codes that have been modified and apply to Medicare by October 7, 2013, per Attachment I and Attachment II for CARC and RARC changes respectively. **NOTE:** Some modifications may become effective at a future date. Contractors shall make sure that modifications are implemented **on the effective date** (which may be later than the implementation date mentioned in this CR) for those code modifications that are being used by Medicare.	X	X		X	X	X	X					
8422.2	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
8422.3	Contractors shall update reason and remark codes to include new codes that apply to Medicare by October 7, 2013, if and as instructed by CMS. See Attachment I and II for CARC and RARC changes	X	X		X	X	X	X					

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
	respectively since CR 8281. **NOTE:** Some new codes may become effective at a future date. Contractors shall make sure that new codes are implemented, if directed by CMS, on the effective date as posted on the WPC website or later as directed												
8422.4	FISS, MCS, and VMS 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 October 7, 2013. **NOTE:** Check the updated lists as posted on the WPC Web site to capture deactivations that were included in previous CR(s).								X	X	X		
8422.5	FISS, MCS, and VMS shall update any crosswalk between the standard reason and remark codes and the shared system internal codes provided to the contractors and make any standard code deactivated since the last update unavailable for use by the contractor by October 7, 2013.								X	X	X		
8422.6	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;** • 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
8422.7	FISS, MCS, and VMS 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		

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
8422.8	VMS shall update the Medicare Remit Easy Print (MREP) software by October 7, 2013. This update shall be based on the CARC and RARC lists as posted on WPC Web site on July 1 and July 15, 2013, respectively.										X		
8422.9	FISS shall update the PC Print software by October 7, 2013. This update shall be based on the CARC and RARC lists as posted on WPC Web site on July 1 and July 15, 2013, respectively.								X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility							
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Other
		A	B	HHH					
8422.10	MLN Article : A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/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 sites 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 the contractor's 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	X	X	

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Sumita Sen, sumita.sen@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with 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 do 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.

ATTACHMENT(S): 2

CR 8422
ATTACHMENT I: Changes in CARC List since CR 8281
New Codes – CARC:

Code	Narrative	Effective Date
253	Sequestration - reduction in federal spending .	06/02/2013
254	Claim received by the dental plan, but benefits not available under this plan. Submit these services to the patient's medical plan for further consideration.	06/02/2013
255	The disposition of the related Property & Casualty claim (injury or illness) is pending due to litigation. (Use only with Group Code OA)	06/02/2013
256	Service not payable per managed care contract.	06/02/2013
W5	Medical provider not authorized/certified to provide treatment to injured workers in this jurisdiction. (Use with Group Code CO or OA)	06/02/2013
W6	Referral not authorized by attending physician per regulatory requirement.	06/02/2013
W7	Procedure is not listed in the jurisdiction fee schedule. An allowance has been made for a comparable service.	06/02/2013
W8	Procedure has a relative value of zero in the jurisdiction fee schedule, therefore no payment is due.	06/02/2013
W9	**Service not paid under jurisdiction allowed outpatient facility fee schedule.**	06/02/2013

Modified Codes – CARC:

Code	Modified Narrative	Effective Date
16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	06/02/2013
18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	06/02/2013
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability)	07/01/2013
136	Failure to follow prior payer's coverage rules. (Use only with Group Code OA)	07/01/2013
163	Attachment/other documentation referenced on the claim was not received.	06/02/2013
164	Attachment/other documentation referenced on the claim was not received in a timely fashion.	06/02/2013
173	**Service/equipment was not prescribed by a physician.**	07/01/2013
201	Workers' Compensation case settled. Patient is responsible for amount of this claim/service through WC 'Medicare set aside arrangement' or other agreement. (Use only with Group Code PR)	07/01/2013
209	Per regulatory or other agreement. The provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to patient if collected. (Use only with Group code OA)	07/01/2013
221	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). (Note: To be used by Property & Casualty only)	07/01/2013
226	Information requested from the Billing/Rendering Provider was not provided or not provided timely or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	07/01/2013
229	Partial charge amount not considered by Medicare due to	07/01/2013

	the initial claim Type of Bill being 12X. Note: This code can only be used in the 837 transaction to convey Coordination of Benefits information when the secondary payer's cost avoidance policy allows providers to bypass claim submission to a prior payer. (Use only with Group Code PR)	
236	This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/ fee schedule requirements.	07/01/2013
238	Claim spans eligible and ineligible periods of coverage, this is the reduction for the ineligible period. (Use only with Group Code PR)	07/01/2013
242	Services not provided by network/primary care providers *Notes: This code replaces deactivated code 38*	06/02/2013
243	Services not authorized by network/primary care providers. *Notes: This code replaces deactivated code 38*	06/02/2013
250	The attachment/other documentation content received is inconsistent with the expected content.	06/02/2013
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	06/02/2013
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	06/02/2013
W1	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) if the regulations apply.	06/02/2013
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') if the jurisdictional regulation applies. 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) if the regulations apply. To be used for Workers' Compensation only.	06/02/2013
Y1	Payment denied based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits 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	06/02/2013

	2100 Other Claim Related Information REF qualifier 'IG') if the jurisdictional regulation applies. 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) if the regulations apply. To be used for P&C Auto only.	
Y2	Payment adjusted based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits 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') if the jurisdictional regulation applies. 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) if the regulations apply. To be used for P&C Auto only.	06/02/2013
Y3	Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits 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) if the regulations apply. To be used for P&C Auto only.	06/02/2013

Deactivated Codes (Also included in CR 8281) – CARC

Code	Current Narrative	Effective Date
125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	11/01/2013

These are changes in the CARC database since the last code update CR 8154. The full CARC list must be downloaded from the WPC website:
http://wpc-edi.com/Reference

CR 8422
ATTACHMENT II: Changes in RARC List since CR 8281
New – RARC:

Code	Current Narrative	Effective Date
N574	Our records indicate the ordering/referring provider is of a type/specialty that cannot order or refer. Please verify that the claim ordering/referring provider information is accurate or contact the ordering/referring provider.	07/15/2013
N575	Mismatch between the submitted ordering/referring provider name and the ordering/referring provider name stored in our records.	07/15/2013
N576	Services not related to the specific incident/claim/accident/loss being reported.	07/15/2013
N577	Personal Injury Protection (PIP) Coverage.	07/15/2013
N578	Coverages do not apply to this loss.	07/15/2013
N579	Medical Payments Coverage (MPC).	07/15/2013
N580	Determination based on the provisions of the insurance policy.	07/15/2013
N581	Investigation of coverage eligibility is pending.	07/15/2013
N582	Benefits suspended pending the patient's cooperation.	07/15/2013
N583	Patient was not an occupant of our insured vehicle and therefore, is not an eligible injured person.	07/15/2013
N584	Not covered based on the insured's noncompliance with policy or statutory conditions.	07/15/2013
N585	Benefits are no longer available based on a final injury settlement.	07/15/2013
N586	The injured party does not qualify for benefits.	07/15/2013
N587	Policy benefits have been exhausted.	07/15/2013
N588	The patient has instructed that medical claims/bills are not to be paid.	07/15/2013
N589	Coverage is excluded to any person injured as a result of operating a motor vehicle while in an intoxicated condition or while the ability to operate such a vehicle is impaired by the use of a drug.	07/15/2013
N590	Missing independent medical exam detailing the cause of injuries sustained and medical necessity of services rendered.	07/15/2013
N591	Payment based on an Independent Medical Examination (IME) or Utilization Review (UR).	07/15/2013
N592	Adjusted because this is not the initial prescription or exceeds the amount allowed for the initial prescription.	07/15/2013
N593	Not covered based on failure to attend a scheduled Independent Medical Exam (IME).	07/15/2013
N594	Records reflect the injured party did not complete an Application for Benefits for this loss.	07/15/2013
N595	Records reflect the injured party did not complete an Assignment of Benefits for this loss.	07/15/2013
N596	Records reflect the injured party did not complete a Medical Authorization for this loss.	07/15/2013
N597	Adjusted based on a medical provider's apportionment of care between related injuries and other unrelated medical conditions/injuries.	07/15/2013
N598	Health care policy coverage is primary.	07/15/2013
N599	Our payment for this service is based upon a reasonable amount pursuant to both the terms and conditions of the policy of insurance under which the subject claim is being made as well as the Florida No-Fault Statute, which permits, when determining a reasonable charge for	07/15/2013

	a service, an insurer to consider usual and customary charges and payments accepted by the provider, reimbursement levels in the community and various federal and state fee schedules applicable to automobile and other insurance coverages, and other information relevant to the reasonableness of the reimbursement for the service. The payment for this service is based upon 200% of the Participating Level of Medicare Part B fee schedule for the locale in which the services were rendered.	
N600	Adjusted based on the applicable fee schedule for the region in which the service was rendered.	07/15/2013
N601	In accordance with Hawaii Administrative Rules, Title 16, Chapter 23 Motor Vehicle Insurance Law payment is recommended based on Medicare Resource Based Relative Value Scale System applicable to Hawaii.	07/15/2013
N602	Adjusted based on the Redbook maximum allowance.	07/15/2013
N603	This fee is calculated according to the New Jersey medical fee schedules for Automobile Personal Injury Protection and Motor Bus Medical Expense Insurance Coverage.	07/15/2013
N604	In accordance with New York No-Fault Law, Regulation 68, this base fee was calculated according to the New York Workers' Compensation Board Schedule of Medical Fees, pursuant to Regulation 83 and / or Appendix 17-C of 11 NYCRR.	07/15/2013
N605	This fee was calculated based upon New York All Patients Refined Diagnosis Related Groups (APR-DRG), pursuant to Regulation 68.	07/15/2013
N606	The Oregon allowed amount for this procedure is based upon the Workers Compensation Fee Schedule (OAR 436-009). The allowed amount has been calculated in accordance with Section 4 of ORS 742.524.	07/15/2013
N607	Service provided for non-compensable condition(s).	07/15/2013
N608	The fee schedule amount allowed is calculated at 110% of the Medicare Fee Schedule for this region, specialty and type of service. This fee is calculated in compliance with Act 6.	07/15/2013
N609	80% of the providers billed amount is being recommended for payment according to Act 6.	07/15/2013
N610	Alert: Payment based on an appropriate level of care.	07/15/2013
N611	Claim in litigation. Contact insurer for more information.	07/15/2013
N612	Medical provider not authorized/certified to provide treatment to injured workers in this jurisdiction.	07/15/2013
N613	Alert: Although this was paid, you have billed with an ordering provider that needs to update their enrollment record. Please verify that the ordering provider information you submitted on the claim is accurate and if it is, contact the ordering provider instructing them to update their enrollment record. Unless corrected, a claim with this ordering provider will not be paid in the future.	07/15/2013
N614	Alert: Additional information is included in the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information).	07/15/2013
N615	Alert: This enrollee receiving advance payments of the premium tax credit is in the grace period of three consecutive months for non-payment of premium. Under the Code of Federal Regulations, Title 45, Part 156.270, a Qualified Health Plan issuer must pay all appropriate claims for services rendered to the enrollee during the first month of the grace period and may pend claims for services rendered to the enrollee in the second and third months of the grace period.	07/15/2013

N616	Alert: This enrollee is in the first month of the advance premium tax credit grace period.	07/15/2013
N617	This enrollee is in the second or third month of the advance premium tax credit grace period.	07/15/2013
N618	Alert: This claim will automatically be reprocessed if the enrollee pays their premiums.	07/15/2013
N619	Coverage terminated for non-payment of premium.	07/15/2013
N620	Alert: This procedure code is for quality reporting/informational purposes only.	07/15/2013
N621	Charges for Jurisdiction required forms, reports, or chart notes are not payable.	07/15/2013
N622	Not covered based on the date of injury/accident.	07/15/2013
N623	Not covered when deemed unscientific/unproven/outmoded/experimental/excessive/inappropriate.	07/15/2013
N624	The associated Workers' Compensation claim has been withdrawn.	07/15/2013
N625	Missing/Incomplete/Invalid Workers' Compensation Claim Number.	07/15/2013
N626	New or established patient E/M codes are not payable with chiropractic care codes.	07/15/2013
N627	Service not payable per managed care contract.	07/15/2013
N628	Out-patient follow up visits on the same date of service as a scheduled test or treatment is disallowed.	07/15/2013
N629	Reviews/documentation/notes/summaries/reports/charts not requested.	07/15/2013
N630	Referral not authorized by attending physician.	07/15/2013
N631	Medical Fee Schedule does not list this code. An allowance was made for a comparable service.	07/15/2013
N632	According to the Official Medical Fee Schedule this service has a relative value of zero and therefore no payment is due.	07/15/2013
N633	Additional anesthesia time units are not allowed.	07/15/2013
N634	The allowance is calculated based on anesthesia time units.	07/15/2013
N635	The Allowance is calculated based on the anesthesia base units plus time.	07/15/2013
N636	Adjusted because this is reimbursable only once per injury.	07/15/2013
N637	Consultations are not allowed once treatment has been rendered by the same provider.	07/15/2013
N638	Reimbursement has been made according to the home health fee schedule.	07/15/2013
N639	Reimbursement has been made according to the inpatient rehabilitation facilities fee schedule.	07/15/2013
N640	Exceeds number/frequency approved/allowed within time period.	07/15/2013
N641	Reimbursement has been based on the number of body areas rated.	07/15/2013
N642	Adjusted when billed as individual tests instead of as a panel.	07/15/2013
N643	The services billed are considered Not Covered or Non-Covered (NC) in the applicable state fee schedule..	07/15/2013
N644	Reimbursement has been made according to the bilateral procedure rule.	07/15/2013
N645	Mark-up allowance	07/15/2013
N646	Reimbursement has been adjusted based on the guidelines for an assistant.	07/15/2013
N647	Adjusted based on diagnosis-related group (DRG).	07/15/2013
N648	Adjusted based on Stop Loss.	07/15/2013
N649	Payment based on invoice.	07/15/2013

N650	This policy was not in effect for this date of loss. No coverage is available.	07/15/2013
N651	No Personal Injury Protection/Medical Payments Coverage on the policy at the time of the loss.	07/15/2013
N652	The date of service is before the date of loss.	07/15/2013
N653	The date of injury does not match the reported date of loss.	07/15/2013
N654	Adjusted based on achievement of maximum medical improvement (MMI).	07/15/2013
N655	Payment based on provider's geographic region.	07/15/2013
N656	An interest payment is being made because benefits are being paid outside the statutory requirement.	07/15/2013
N657	This should be billed with the appropriate code for these services.	07/15/2013
N658	The billed service(s) are not considered medical expenses.	07/15/2013
N659	This item is exempt from sales tax.	07/15/2013
N660	Sales tax has been included in the reimbursement.	07/15/2013
N661	Documentation does not support that the services rendered were medically necessary.	07/15/2013
N662	Alert: Consideration of payment will be made upon receipt of a final bill.	07/15/2013
N663	Adjusted based on an agreed amount.	07/15/2013
N664	Adjusted based on a legal settlement.	07/15/2013
N665	Services by an unlicensed provider are not reimbursable.	07/15/2013
N666	Only one evaluation and management code at this service level is covered during the course of care.	07/15/2013
N667	Missing prescription	07/15/2013
N668	Incomplete/invalid prescription	07/15/2013
N669	Adjusted based on the Medicare fee schedule.	07/15/2013
N670	This service code has been identified as the primary procedure code subject to the Medicare Multiple Procedure Payment Reduction (MPPR) rule.	07/15/2013
N671	Payment based on a jurisdiction cost-charge ratio.	07/15/2013
N672	Alert: Amount applied to Health Insurance Offset.	07/15/2013
N673	Reimbursement has been calculated based on an outpatient per diem or an outpatient factor and/or fee schedule amount.	07/15/2013
N674	Not covered unless a pre-requisite procedure/service has been provided.	07/15/2013
N675	Additional information is required from the injured party.	07/15/2013
N676	Service does not qualify for payment under the Outpatient Facility Fee Schedule.	07/15/2013

Modified Codes – RARC

Code	Current Narrative	Effective Date
N1	Alert: You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract, plan benefit documents or jurisdiction statutes.	07/15/2013
N7	Alert: Processing of this claim/service has included consideration under Major Medical provisions.	07/15/2013
N10	Payment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	07/15/2013

N441	This missed/cancelled appointment is not covered.	07/15/2013

Deactivated Codes – RARC NONE

These are changes in the RCARC database since the last code update CR 8281. The full RARC list must be downloaded from the WPC website:
http://www.wpc-edi.com/Reference