| CMS Manual System | Department of Health & Human Services (DHHS) |
|---|---|
| Pub 100-04 Medicare Claims Processing | Centers for Medicare & Medicaid Services (CMS) |
| **Transmittal 2855** | **Date: January 10, 2014** |
| | **Change Request 8561** |

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

**I. SUMMARY OF CHANGES:** The purpose of this Change Request (CR) is to update the Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) lists to the most recently published version. Additionaly this CR provides instructions to VIPs and FISS to update Medicare Remit Easy Print (MREP) and PC Print systems. This Recurring Updated Notification Applies to Chapter 22, Sections 40.5, 60.1, and 60.2.

**EFFECTIVE DATE: April 1, 2014**
**IMPLEMENTATION DATE: April 7, 2014**

***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

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

**III. FUNDING:**

**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: 2855 | Date: January 10, 2014 | Change Request: 8561 |
|---|---|---|---|

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

**EFFECTIVE DATE: April 1, 2014**
**IMPLEMENTATION DATE: April 7, 2014**

## 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 three 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 8422, Transmittal 2776, issued on August 30, 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 three 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 | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| 8561.1 | Contractors shall update reason and remark codes that have been modified and apply to Medicare by April 7, 2014 per Attachment I and Attachment II for CARC and RARC changes respectively.<br><br>**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 | | |
| 8561.2 | B MACs 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 | | | | | | | CEDI |
| 8561.3 | Contractors shall update reason and remark codes to | X | X | X | X | | | X | | |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| | include new codes that apply to Medicare by April 7, 2014, if and as instructed by CMS. See Attachment I and II for CARC and RARC changes respectively since CR 8422.<br><br>**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 | | | | | | | | | |
| 8561.4 | 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 April 7, 2014.<br><br>**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 | | |
| 8561.5 | 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 April 7, 2014. | | | | | X | X | | | |
| 8561.6 | 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:<br><br>• **Medicare is not primary;**<br><br>• The COB claim is received after the deactivation effective date; and<br><br>• 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 | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| 8561.7 | 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 | | |
| 8561.8 | VMS shall update the Medicare Remit Easy Print (MREP) software by April 7, 2014. This update shall be based on the CARC and RARC lists as posted on WPC Web site on November 1, 2013 respectively. | | | | | | | X | | |
| 8561.9 | FISS shall update the PC Print software by April 7, 2014. This update shall be based on the CARC and RARC lists as posted on WPC Web site on November 1, 2013. | | | | | X | | | | |

## III. PROVIDER EDUCATION TABLE

| Number | Requirement | Responsibility | | | | |
|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | CEDI |
| | | A | B | HHH | | |
| 8561.10 | 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 |

## 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, Lauren Vandegrift, 410-786-4882 or Lauren.vandegrift@cms.hhs.gov

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

## VI. FUNDING

**Section A: 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.

Attachment (s): 2

# CR 8561
# ATTACHMENT I: Changes in CARC List since CR 8422

## New Codes – CARC:

| | | |
|---|---|---|
| 257 | The disposition of the claim/service is pending during the premium payment grace period, per Health Insurance Exchange requirements. (Use only with Group Code OA) | 11/01/2013 |
| 258 | Claim/service not covered when patient is in custody/incarcerated. Applicable federal, state or local authority may cover the claim/service. | 11/01/2013 |
| P1 | State-mandated Requirement for Property and Casualty, see Claim Payment Remarks Code for specific explanation. To be used for Property and Casualty only. | 11/01/2013 |
| P2 | 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). To be used for Workers' Compensation only. | 11/01/2013 |
| P3 | Workers' Compensation case settled. Patient is responsible for amount of this claim/service through WC 'Medicare set aside arrangement' or other agreement. To be used for Workers' Compensation only. (Use only with Group Code PR) | 11/01/2013 |
| P4 | 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 | 11/01/2013 |
| P5 | Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement. To be used for Property and Casualty only. | 11/01/2013 |
| P6 | 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 Service Payment information REF). To be used for Property and Casualty only. | 11/01/2013 |
| P7 | The applicable fee schedule/fee database does not contain the billed code. Please resubmit a bill with the appropriate fee schedule/fee database code(s) that best describe the service(s) provided and supporting documentation if required. To be used for Property and Casualty only. | 11/01/2013 |
| P8 | 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). To be used for Property and Casualty only. | 11/01/2013 |

| | | |
|---|---|---|
| P9 | No available or correlating CPT/HCPCS code to describe this service. To be used for Property and Casualty only. | 11/01/2013 |
| P10 | Payment reduced to zero due to litigation. Additional information will be sent following the conclusion of litigation. To be used for Property and Casualty only. | 11/01/2013 |
| P11 | The disposition of the related Property & Casualty claim (injury or illness) is pending due to litigation. To be used for Property and Casualty only. (Use only with Group Code OA) | 11/01/2013 |
| P12 | 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. To be used for Workers' Compensation only. | 11/01/2013 |
| P13 | 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. | 11/01/2013 |
| P14 | The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. To be used for Property and Casualty only. | 11/01/2013 |
| P15 | Workers' Compensation Medical Treatment Guideline Adjustment. To be used for Workers' Compensation only. | 11/01/2013 |
| P16 | Medical provider not authorized/certified to provide treatment to injured workers in this jurisdiction. To be used for Workers' Compensation only. (Use with Group Code CO or OA | 11/01/2013 |
| P17 | Referral not authorized by attending physician per regulatory requirement. To be used for Property and Casualty only | 11/01/2013 |
| P18 | Procedure is not listed in the jurisdiction fee schedule. An allowance has been made for a comparable service. To be used for Property and Casualty only. | 11/01/2013 |
| P19 | Procedure has a relative value of zero in the jurisdiction fee schedule, therefore no payment is due. To be used for Property and Casualty only. | 11/01/2013 |
| P20 | Service not paid under jurisdiction allowed outpatient facility fee schedule. To be used for Property and Casualty only. | 11/01/2013 |
| P21 | 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 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 Property and Casualty Auto only. | 11/01/2013 |
| P22 | 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 | 11/01/2013 |

| | | |
|---|---|---|
| | 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 Property and Casualty Auto only. | |
| P23 | 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 Property and Casualty Auto only. | 11/01/2013 |

## Modified Codes – CARC:

| Code | Modified Narrative | Effective Date |
|---|---|---|
| 49 | This is a non-covered service because it is a routine/preventive exam or a diagnostic/screening procedure done in conjunction with a routine/preventive exam. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. | 11/01/2013 |
| 253 | Sequestration - reduction in federal payment | 11/01/2013 |

## Deactivated Codes – CARC

| Code | Current Narrative | Effective Date |
|---|---|---|
| 162 | State-mandated Requirement for Property and Casualty, see Claim Payment Remarks Code for specific explanation. | 07/01/2014 |
| 191 | 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) | 07/01/2014 |
| 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) | 07/01/2014 |
| 214 | 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 | 07/01/2014 |
| 217 | Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement. (Note: To be used for Property and Casualty only) | 07/01/2014 |
| 218 | 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 Service Payment information REF). To be used for Workers' | 07/01/2014 |

| | | |
|---|---|---|
| | Compensation only | |
| 220 | The applicable fee schedule/fee database does not contain the billed code. Please resubmit a bill with the appropriate fee schedule/fee database code(s) that best describe the service(s) provided and supporting documentation if required. (Note: To be used for Property and Casualty only) | 07/01/2014 |
| 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) | 07/01/2014 |
| 230 | No available or correlating CPT/HCPCS code to describe this service. Note: Used only by Property and Casualty. | 07/01/2014 |
| 244 | Payment reduced to zero due to litigation. Additional information will be sent following the conclusion of litigation. To be used for Property & Casualty only. | 07/01/2014 |
| 255 | The disposition of the related Property & Casualty claim (injury or illness) is pending due to litigation. (Use only with Group Code OA) | 07/01/2014 |
| 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. | 07/01/2014 |
| 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. | 07/01/2014 |
| W3 | The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. For use by Property and Casualty only. | 07/01/2014 |
| W4 | Workers' Compensation Medical Treatment Guideline Adjustment. | 07/01/2014 |
| W5 | Medical provider not authorized/certified to provide treatment to injured workers in this jurisdiction. (Use with Group Code CO or OA) | 07/01/2014 |
| W6 | Referral not authorized by attending physician per regulatory requirement. | 07/01/2014 |
| W7 | Procedure is not listed in the jurisdiction fee schedule. An allowance has been made for a comparable service. | 07/01/2014 |
| W8 | Procedure has a relative value of zero in the jurisdiction fee schedule, therefore no payment is due. | 07/01/2014 |
| W9 | Service not paid under jurisdiction allowed outpatient facility fee schedule. | 07/01/2014 |
| 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 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. | 07/01/2014 |
| 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 | 07/01/2014 |

| | | |
|---|---|---|
| | 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. | |
| 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. | 07/01/2014 |

These are changes in the CARC database since the last code update CR 8422. The full CARC list must be downloaded from the WPC website: http://wpc-edi.com/Reference

# CR 8561
# ATTACHMENT II: Changes in RARC List since CR 8422

## New Codes – RARC:

| | | |
|---|---|---|
| N677 | Alert: Films/Images will not be returned. | 11/1/2013 |
| N678 | Missing post-operative images/visual field results. | 11/1/2013 |
| N679 | Incomplete/Invalid post-operative images/visual field results. | 11/1/2013 |
| N680 | Missing/Incomplete/Invalid date of previous dental extractions. | 11/1/2013 |
| N681 | Missing/Incomplete/Invalid full arch series. | 11/1/2013 |
| N682 | Missing/Incomplete/Invalid history of prior periodontal therapy/maintenance. | 11/1/2013 |
| N683 | Missing/Incomplete/Invalid prior treatment documentation. | 11/1/2013 |
| N684 | Payment denied as this is a specialty claim submitted as a general claim. | 11/1/2013 |
| N685 | Missing/Incomplete/Invalid Prosthesis, Crown or Inlay Code. | 11/1/2013 |
| N686 | Missing/incomplete/invalid questionnaire needed to complete payment determination. | 11/1/2013 |
| N687 | Alert - This reversal is due to a retroactive disenrollment. (Note: To be used with claim/service reversal) | 11/1/2013 |
| N688 | Alert – This reversal is due to a medical or utilization review decision. (Note: To be used with claim/service reversal) | 11/1/2013 |
| N689 | Alert –This reversal is due to a retroactive rate change. (Note: To be used with claim/service reversal) | 11/1/2013 |
| N690 | Alert – This reversal is due to a provider submitted appeal. (Note: To be used with claim/service reversal) | 11/1/2013 |
| N691 | Alert – This reversal is due to a patient submitted appeal. (Note: To be used with claim/service reversal) | 11/1/2013 |
| N692 | Alert – This reversal is due to an incorrect rate on the initial adjudication (Note: To be used with claim/service reversal) | 11/1/2013 |

| | | |
|---|---|---|
| N693 | Alert – This reversal is due to a cancelation of the claim by the provider. | 11/1/2013 |
| N694 | Alert – This reversal is due to a resubmission/change to the claim by the provider. | 11/1/2013 |
| N695 | Alert – This reversal is due to incorrect patient financial responsibility information on the initial adjudication. | 11/1/2013 |
| N696 | Alert – This reversal is due to a Coordination of Benefits or Third Party Liability Recovery retroactive adjustment.<br>(Note: To be used with claim/service reversal) | 11/1/2013 |
| N697 | Alert – This reversal is due to a payer's retroactive contract incentive program adjustment.<br>(Note: To be used with claim/service reversal) | 11/1/2013 |
| N698 | Alert – This reversal is due to non-payment of the Health Insurance Exchange premiums by the end of the premium payment grace period, resulting in loss of coverage.<br>(Note: To be used with claim/service reversal) | 11/1/2013 |

## Modified Codes – RARC:

| Code | Modified Narrative | Effective Date |
|---|---|---|
| N102 | This claim has been denied without reviewing the medical/dental record because the requested records were not received or were not received timely. | 11/01/2013 |
| N103 | Records indicate this patient was a prisoner or in custody of a Federal, State, or local authority when the service was rendered. This payer does not cover items and services furnished to an individual while he or she is in custody under a penal statute or rule, unless under State or local law, the individual is personally liable for the cost of his or her health care while in custody and the State or local government pursues the collection of such debt in the same way and with the same vigor as the collection of its other debts. The provider can collect from the Federal/State/ Local Authority as appropriate. | 11/01/2013 |
| N178 | Missing pre-operative images/visual field results | 11/01/2013 |
| N244 | Incomplete/Invalid pre-operative images/visual field results. | 11/01/2013 |
| N597 | Adjusted based on a medical/dental provider's apportionment of care between related injuries and other unrelated medical/dental conditions/injuries. | 11/01/2013 |

## Deactivated Codes – RARC

| Code | Current Narrative | Effective Date |
|---|---|---|
| N365 | This procedure code is not payable. It is for reporting/information purposes only. | 07/01/2014 |
| N627 | Service not payable per managed care contract. | 07/01/2014 |
| N632 | According to the Official Medical Fee Schedule this service has a relative value of zero and therefore no payment is due. | 07/01/2014 |

These are changes in the RARC database since the last code update CR 8422. The full RARC list must be downloaded from the WPC website: http://wpc-edi.com/Reference