CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2920	**Date: April 4, 2014**
	Change Request 8703

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: July 1, 2014
IMPLEMENTATION DATE: July 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-*Only One Per Row.*

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: 2920	Date: April 4, 2014	Change Request: 8703

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

EFFECTIVE DATE: July 1, 2014
IMPLEMENTATION DATE: July 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 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 8561, Transmittal 2855, issued on January 10, 2014), 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, even if not initiated by Medicare, will be implemented

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	
8703.1	Contractors shall update reason and remark codes that have been modified and apply to Medicare by July 7, 2014, 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					
8703.2	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							CEDI
8703.3	Contractors shall update reason and remark codes to include new codes that apply to Medicare by July 7, 2014, if and as instructed by CMS. See Attachment I and II for CARC and RARC changes respectively since CR 8561.	X	X	X	X					

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	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									
8703.4	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 July 7, 2014. **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		
8703.5	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 July 7, 2014.					X	X	X		
8703.6	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
8703.7	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		
8703.8	VMS shall update the Medicare Remit Easy Print (MREP) software by July 7, 2014. This update shall be based on the CARC and RARC lists as posted on WPC Web site on March 1, 2014.							X		
8703.9	*FISS shall update the PC Print software by July 7,*					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	2014. This update shall be based on the CARC and RARC lists as posted on WPC Web site on March 1, 2014.									

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
8703.10	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

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

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 8703

ATTACHMENT I: Changes in CARC List since CR 8561

New Codes – CARC:

259	Additional payment for Dental/Vision service utilization.	01/26/2014
260	Processed under Medicaid ACA Enhanced Fee Schedule	1/26/2014

Modified Codes – CARC:

Code	Modified Narrative	Effective Date
257	The disposition of the claim/service is undetermined during the premium payment grace period, per Health Insurance Exchange requirements. This claim/service will be reversed and corrected when the grace period ends (due to premium payment or lack of premium payment). (Use only with Group Code OA) **Notes: To be used for months 2 and 3 in the grace period.**	1/26/2014

Deactivated Codes – CARC

Code	Current Narrative	Effective Date
A7	Presumptive Payment Adjustment	7/1/2015

These are changes in the CARC database since the last code update CR 8561. The full CARC list must be downloaded from the WPC website:
http://wpc-edi.com/Reference

CR 8703

ATTACHMENT II: Changes in RARC List since CR 8561

New Codes – RARC:

N699	Payment adjusted based on the Physician Quality Reporting System (PQRS) Incentive Program.	3/1/2014
N700	Payment adjusted based on the Electronic Health Records (EHR) Incentive Program.	3/1/2014
N701	Payment adjusted based on the Value-based Payment Modifier.	3/1/2014
N702	Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services.	3/1/2014
N703	This service is incompatible with previously adjudicated claims or claims in process.	3/1/2014
N704	Alert: You may not appeal this decision but can resubmit this claim/service with corrected information if warranted.	3/1/2014
N705	Incomplete/invalid documentation.	3/1/2014
N706	Missing documentation.	3/1/2014
N707	Incomplete/invalid orders.	3/1/2014
N708	Missing orders.	3/1/2014
N709	Incomplete/invalid notes	3/1/2014
N710	Missing notes	3/1/2014
N711	Incomplete/invalid summary.	3/1/2014
N712	Missing summary.	3/1/2014
N713	Incomplete/invalid report.	3/1/2014
N714	Missing report.	3/1/2014
N715	Incomplete/invalid chart.	3/1/2014

N716	Missing chart.	3/1/2014
N717	Incomplete/Invalid documentation of face-to-face examination.	3/1/2014
N718	Missing documentation of face-to-face examination.	3/1/2014
N719	Penalty applied based on plan requirements not being met.	3/1/2014
N720	Alert: The patient overpaid you. You may need to issue the patient a refund for the difference between the patient's payment and the amount shown as patient responsibility on this notice.	3/1/2014
N721	This service is only covered when performed as part of a clinical trial.	3/1/2014
N722	Patient must use Workers' Compensation Set-Aside (WCSA) funds to pay for the medical service or item.	3/1/2014
N723	Patient must use Liability set-aside (LSA) funds to pay for the medical service or item.	3/1/2014
N724	Patient must use No-Fault set-aside (NFSA) funds to pay for the medical service or item.	3/1/2014
N725	A liability insurer has reported having ongoing responsibility for medical services (ORM) for this diagnosis.	3/1/2014
N726	A conditional payment is not allowed.	3/1/2014
N727	A no-fault insurer has reported having ongoing responsibility for medical services (ORM) for this diagnosis.	3/1/2014
N728	A workers' compensation insurer has reported having ongoing responsibility for medical services (ORM) for this diagnosis.	3/1/2014

Modified Codes – RARC:

Code	Modified Narrative	Effective Date
MA50	Missing/incomplete/invalid Investigational Device Exemption number or Clinical Trial number. Start: 01/01/1997 | Last Modified: 03/01/2014 Notes: (Modified 2/28/03, 3/1/2014)	03/1/2014
M77	Missing/incomplete/invalid/inappropriate place of service. *Start: 01/01/1997 | Last Modified: 03/01/2014* *Notes: (Modified 2/28/03, 3/1/2014)*	03/1/2014
N29	Missing documentation/orders/notes/summary/report/chart. Start: 01/01/2000 | Stop: 03/01/2016 | Last Modified: 03/01/2014 Notes: (Modified 2/28/03, 8/1/05, 3/1/2014) Related to N225, Explicit RARCs have been approved, this non-specific RARC will be deactivated in March 2016.	3/1/2014

N225	Incomplete/invalid documentation/orders/notes/summary/report/chart. Start: 08/01/2004 | Stop: 03/01/2016 | Last Modified: 03/01/2014 Notes: (Modified 8/1/05, 3/1/2014) Explicit RARCs have been approved, this non-specific RARC will be deactivated in March 2016.	3/1/2014

Deactivated Codes – RARC

Code	Current Narrative	Effective Date

These are changes in the RARC database since the last code update CR 8561-. The full RARC list must be downloaded from the WPC website:
http://wpc-edi.com/Reference