CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1031	**Date: AUGUST 18, 2006**
	Change Request 5212

SUBJECT: Remittance Advice Remark Code and Claim Adjustment Reason Code Update

I. SUMMARY OF CHANGES: This CR lists all changes in the Remittance Advice Remark Code and Claim Adjustment Reason Code lists included in the April 2006 and February 2006 updates respectively.

NEW / REVISED MATERIAL
EFFECTIVE DATE: *October 1, 2006
IMPLEMENTATION DATE: October 2, 2006

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:
No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

Recurring Update Notification

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

Attachment – Recurring Update Notification

Pub.100-04	Transmittal: 1031	Date: August 18, 2006	Change Request 5212

SUBJECT: **Remittance Advice Remark Code and Claim Adjustment Reason Code Update**

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 Remittance Advice Remark Codes (RARCs) are required in the remittance advice transaction.

X12N 835 Health Care 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. As the recognized maintainer of the RARC, CMS receives a significant number of requests for new remark codes and modifications in existing remark codes from Medicare and non-Medicare entities. Additions and modifications to the code list resulting from non-Medicare requests may not impact Medicare.

Remark and reason code changes that impact Medicare are requested by CMS staff in conjunction with a policy change. Contractors are notified about these changes in the corresponding instructions, which implement 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. If a new code is not initiated by Medicare, contractors do not have to use it unless they have received specific instruction from CMS. 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 shall not use any deactivated 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

The list is updated 3 times a year. By October 2, 2006 you must have completed entry of all applicable code text changes and new codes, and terminated use of deactivated codes.

You must use the latest approved and valid codes in your 835, corresponding standard paper remittance advice, and coordination of benefits transactions. The following list summarizes changes made from November 1, 2005 to February 28, 2006.

The RARC database has expanded rapidly in the last couple of years. CMS has developed a new Web site to help navigate the database more easily. A tool is provided to help search if you are looking for a specific category of code. You can also find at this site some other information that are available from the WPC Web site. The new Web site address is: http://www.cmsremarkcodes.info/

NOTE: This Web site is not replacing the WPC Web site as the official site where the most current RARC list resides. If there is any discrepancy, always use the list posted at the WPC Web site.

Remittance Advice Remark Code changes

New Codes

Code	Current Narrative	Medicare Initiated
N365	This procedure code is not payable. It is for reporting/information purposes only.	Y
N366	Requested information not provided. The claim will be reopened if the information previously requested is submitted within one year after the date of this denial notice.	N
N367	The claim information has been forwarded to a Health Savings Account processor for review.	N
N368	You must appeal the determination of the previously adjudicated claim.	Y
N369	Alert: Although this claim has been processed, it is deficient according to state legislation/regulation.	N

Modified Codes

Code	Current Modified Narrative	Modification Date
MA02	If you do not agree with this determination, you have the right to appeal. You must file a written request for an appeal within 180 days of the date you receive this notice. Decisions made by a Quality Improvement Organization (QIO) must be appealed to that QIO within 60 days.	Modified eff. 12/29/05 (*)

- This modification is effective January 1, 2006, and was implemented on or before May 17, 2006.

Deactivated Codes

MA03	If you do not agree with the approved amounts and $100 or more is in dispute (less deductible and coinsurance), you may ask for a hearing within six months of the date of this notice. To meet the $100, you may combine amounts on other claims that have been denied, including reopened appeals if you received a revised decision. You must appeal each claim on time.	Deactivated effective 10/01/06, consider using Remark code MA02

X12 N 835 Health Care Claim Adjustment Reason Codes

A national code maintenance committee maintains the health care claim adjustment reason codes. The Committee meets at the beginning of each X12 trimester meeting (February, June and October) and makes decisions about additions, modifications, and retirement of existing reason codes. The updated list is posted 3 times a year after each X12 trimester meeting. To access the list select http://www.wpc-edi.com/codes. Select Claim Adjustment Reason Codes from the pull down menu. All reason code changes approved in February 2006 are listed here. By October 2, 2006, you must have completed entry of all applicable code text changes and new codes, and terminated use of deactivated codes. You must use the latest approved and valid codes in your 835, corresponding standard paper remittance advice, and coordination of benefits transactions.

The request for a reason code change may come from either Medicare or non-Medicare entities. If Medicare requests a change, it may be included in a Medicare instruction in addition to this regular code update notification. The regular code update notification is issued on a regular periodic basis to provide a summary of changes in the reason and remark codes introduced since the last update notification, and **will establish the deadline for Medicare contractors to implement the reason and remark code changes that may not already have been implemented as part of a previous Medicare policy change instruction.**

A reason code may be retired if it is no longer applicable or a similar code exists. Retirements may be effective for a specified future and succeeding versions or on a specific date. Contractors can discontinue use of retired codes in prior versions. The regular code update notification will establish the deadline for Medicare contractors to retire a reason code. The Medicare deadline could be earlier than the version or the date specified in the Washington Publishing Company (WPC) posting. The committee approved the following reason code changes in February 2006.

Reason Code Changes

New Codes

Code	Current Narrative	Notes
193	Original payment decision is being maintained. This claim was processed properly the first time.	New as of 2/06
194	Payment adjusted when anesthesia is performed by the operating physician, the assistant surgeon or the attending physician.	New as of 2/06

195	Payment denied/reduced due to a refund issued to an erroneous priority payer for this claim/service	New as of 2/06

Modified Codes

None

Retired Codes

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 must be used to report payment adjustments, appeal rights, and related information. Additionally, for transaction 837 COB, CARC must be used. These code sets are updated on a regular basis. Medicare contractors must use only currently valid codes, and make the necessary changes on a regular basis as per this recurring code update CR or the specific CR that describes the change in policy that resulted in the code change.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5212.1	Intermediaries/RHHIs/Carriers/DMERCs and VMS shall update reason and remark codes that have been modified and apply to Medicare by October 2, 2006.	X	X	X	X			X		
5212.2	Intermediaries/RHHIs/Carriers/DMERCs and VMS shall update reason and remark codes to include new codes that apply to Medicare by October 2, 2006.	X	X	X	X			X		
5212.3	Intermediaries/RHHIs/Carriers/DMERCs and VMS shall update reason and remark codes that have been deactivated whether they apply to Medicare or not by October 2, 2006.	X	X	X	X			X		

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5212.4	VMS shall update the Medicare Remit Easy Print software to include the most current CARC and RARC lists available from the following Web site: http://www.wpc-edi.com/codes							X		
5212.5	If you find any discrepancy between any code text included in this CR and the corresponding text as posted on the Washington Publishing Company (WPC) Web site, use the text posted at the WPC Web site.	X	X	X	X			X		

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5212.6	A provider education article related to this instruction will be available at 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 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. 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					

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: October 1, 2006 **Implementation Date:** October 2, 2006 **Pre-Implementation Contact(s):** Sumita Sen at Sumita.sen@cms.hhs.gov or 410-786-5755 **Post-Implementation Contact(s):** Sumita Sen at Sumita.sen@cms.hhs.gov or 410-786-5755	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.**

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