CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1563	**Date: July 25, 2008**
	Change Request 6109

SUBJECT: Remittance Advice Remark Code (RARC) and Claim Adjustment Reason Code (CARC) Update

I. SUMMARY OF CHANGES: This Change Request (CR) instructs contractors to add or modify reason and remark codes that have been added or modified since CR 5942 (Transmittal 1475 published on March 7, 2008). This CR also instructs specified Shared System Maintainers (SSMs) to deactivate the codes that have been deactivated since CR 5942 (Transmittal 1475 published on March 7, 2008). The attached Recurring Update Notification applies to Chapter 22, section 60 of the IOM.

New / Revised Material
Effective Date: October 1, 2008
Implementation Date: October 6, 2008

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:
SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:
Recurring Update Notification

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

Attachment – Recurring Update Notification

Pub. 100-04	Transmittal: 1563	Date: July 25, 2008	Change Request: 6109

SUBJECT: Remittance Advice Remark Code (RARC) and Claim Adjustment Reason Code (CARC) Update

Effective Date: October 1, 2008

Implementation Date: October 6, 2008

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 (electronic and paper) 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. CMS as the X12 recognized maintainer of RARCs receives requests from Medicare and non-Medicare payers for new codes and modification/deactivation of existing codes. Additions, deletions, and modifications to the code list resulting from non-Medicare requests may or may not impact Medicare.

Remark and reason code changes that impact Medicare are usually requested by CMS staff in conjunction with a policy change. Contractors are notified about these changes in the corresponding instructions from the specific CMS component which implements the policy change, in addition to the regular code update notification. If there is a difference in the implementation date as instructed in the regular code update CR and the CR sent by the individual component, Medicare contractors shall implement the change on the earlier date. If a modification has been initiated by an entity other than CMS for a code currently used by Medicare, contractors shall use the modified code even though the modification was not initiated by Medicare. Shared System Maintainers have the responsibility to implement code deactivation making sure that any deactivated code is not used in original business messages, but the deactivated code in derivative messages is allowed. Contractors shall stop using codes that have been deactivated on or before the effective date specified in the comment section (as posted on the WPC Web site) if they are currently being used. In order to comply with any deactivation, Medicare may have to stop using the deactivated code in original business messages before the actual "Stop Date" posted on WPC Web site because the code list is updated 3 times a year and does not align with the Medicare release schedule. Note that you shall accept a deactivated reason code used in derivative messages even after the code is deactivated**. Medicare contractors shall not use any deactivated reason or remark code past the deactivation date whether the deactivation is requested by Medicare or any other entity**. The complete list of remark codes is available at:

http://www.wpc-edi.com/codes

The RARC list is updated 3 times a year – in early March, July, and November per the following schedule:

Cycle 1: Requests received between Oct – Jan. Update posted on WPC in early March and included in the October code update CR.

Cycle II: Requests received between Feb – May. Update posted on WPC in early July and included in the January code update CR.

Cycle III: Requests received between June – Sep. Update posted on WPC in early Nov. and included in the April code update CR.

The RARC Committee meets every month – the 4th Thursday from January –October and the 3rd Thursday in November and December. The recommendations are posted on WPC Web site for review and comments from the industry and stay there until after the cycle ends and the recommendations are incorporated in the updated list.

By October 6, 2008, contractors shall complete entry of all applicable code text changes and new codes, and the Shared System Maintainers shall implement all code deactivations.

Contractors must use the latest approved and valid codes in the 835, corresponding standard paper remittance advice, and coordination of benefits transactions. CMS has developed a new Web site to help navigate the RARC database more easily. A tool is provided to help search if you are looking for a specific category of code. At this site you can find some other information that is also available from the WPC Web site. The new Web site address is: http://www.cmsremarkcodes.info/

NOTE I: 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.

NOTE II: Some remark codes may only provide general information that may not necessarily supplement the specific explanation provided through a reason code and in some cases another/other remark code(s) for an adjustment. Codes that are "Informational" will have "Alert" in the text to identify them as informational rather than explanatory codes. An example of an informational code:

N369 Alert: Although this claim has been processed, it is deficient according to state legislation/regulation.

The above information is sent per state regulation, but does not explain any adjustment.

These informational codes should be used only if specific information about adjudication (like appeal rights) needs to be communicated but not as default codes. A number of remark codes have been identified as "Informational" and have been modified by adding the word "Alert" in front of the text. These codes may be used without any CARC explaining a specific adjustment.

NOTE III: An "Informational" RARC may not be used as the required supplemental RARC with the 5 CARCs (16, 17, 96, 125, and A1) that now need a supplementary RARC for providing full explanation for the specific adjustment

Remittance Advice Remark Code changes

New Codes

Code	Current Narrative	Medicare Initiated
N433	Resubmit this claim using only your National Provider Identifier (NPI)	Y

Modified Codes

Code	Current Modified Narrative	Last Modified

MA97	Missing/incomplete/invalid Medicare Managed Care Demonstration contract number or clinical trial registry number.	2/29/08
N175	Missing review organization approval.	2/29/08
N241	Incomplete/invalid review organization approval.	2/29/08
N421	Claim payment was the result of a payer's retroactive adjustment due to a review organization decision.	2/29/08

Deactivated Codes

Code	Current Narrative	Last Modified
None		

X12 N 835 Health Care Claim Adjustment Reason Codes

A national code maintenance committee maintains the health care Claim Adjustment Reason Codes (CARCs). The Committee meets at the beginning of each X12 trimester meeting (January/February, June and September/October) and makes decisions about additions, modifications, and retirement of existing reason codes. The updated list is posted 3 times a year around early November, March, and July. To access the list select http://www.wpc-edi.com/codes. Select Claim Adjustment Reason Codes from the pull down menu. The new codes will be effective when approved, and the deactivation and modification become effective at a later date as published on the WPC Web site. A modification may also be effective when approved if the requester provides justification for an earlier implementation/effective date for the change. The regular code update CR will establish the implementation date for Medicare contractors and the Shared System Maintainers. **Medicare contractors shall not use any deactivated reason code past the deactivation date whether the deactivation is requested by Medicare or any other entity, but may stop using a deactivated code in original business messages before the deactivation effective date as posted on the WPC Web site** .

New Codes:

Code	Current Narrative	Effective Date (per WPC Web site)
213	Non-compliance with the physician self referral prohibition legislation or payer policy.	1/27/2008
214	Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment. (Note: To be used for Workers' Compensation only)	1/27/2008
215	Based on subrogation of a third party settlement	1/27/2008
216	Based on the findings of a review organization	1/27/2008
217	Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement. (Note: To be used for Workers' Compensation only)	1/27/2008

218	Based on entitlement to benefits (Note: To be used for Workers' Compensation only)	1/27/2008
219	Based on extent of injury (Note: To be used for Workers' Compensation only)	1/27/2008
220	The applicable fee schedule does not contain the billed code. Resubmit a bill with the appropriate fee schedule code(s) that best describe the service(s) provided and supporting documentation if required. (Note: To be used for Workers' Compensation only)	1/27/2008
221	Workers' Compensation claim is under investigation. (Note: To be used for Workers' Compensation only. Claim pending final resolution)	1/27/2008
D22	Reimbursement was adjusted for the reasons to be provided in separate correspondence. (Note: To be used for Workers' Compensation only) - Temporary code to be added for timeframe only until 01/01/2009. Another code to be established and/or for 06/2008 meeting for a revised code to replace or strategy to use another existing code	1/27/2008

Modified Codes:

Code	**Modified Narrative**	**Effective Date (per WPC Web site)**
151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.	1/27/2008

Deactivated Codes:

Code	**Current Narrative**	**Effective Date (per WPC Web site)**
D22	Reimbursement was adjusted for the reasons to be provided in separate correspondence. (Note: To be used for Workers' Compensation only) - Temporary code to be added for timeframe only until 01/01/2009. Another code to be established and/or for 06/2008 meeting for a revised code to replace or strategy to use another existing code	1/1/2009

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 report only currently valid codes in both the remittance advice and COB Claim transaction. Deactivated codes may be accepted and reported in derivative messages. Shared System Maintainers and contractors must 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 TABLE

"Shall" denotes a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
6109.1	A/B MACs, carriers, DME MACs, FIs, and RHHIs shall update reason and remark codes that have been modified and apply to Medicare by October 6, 2008.	X	X	X	X	X					
6109.2	A/B MACs, carriers, DME MACs, FIs, and RHHIs shall update reason and remark codes to include new codes that apply to Medicare by October 6, 2008.	X	X	X	X	X					
6109.3	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 6, 2008.						X	X	X		
6109.4	FISS, MCS, and VMS shall make necessary programming changes by October 6, 2008, so that deactivated reason and remark codes are allowed in derivative messages even after the deactivation effective date.						X	X	X		
6109.5	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 (Note: This update is provided in a separate file starting in April, 2008.)								X		
6109.6	A/B MACs, carriers, and DME MACs shall notify the users that the code update file must be downloaded to be used in conjunction with the current software. (Note: The software will be updated if there is any enhancement to be implemented. If there is no enhancement needed, the code update file will be used with the existing software).	X	X		X						
6109.7	A/B MACs, carriers, DME MACs, FIs, and RHHIs shall make sure that at least one explanatory RARC is used with CARCs 16, 17, 96, 125, and A1. "Informational" RARCs with "Alert" in the text can not be used as the required RARC, but can be used as additional RARC(s) with these	X	X	X	X	X					

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
	generic CARCs.										

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
6109.8	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X	X	X	X					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:
"Should" denotes a recommendation.

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

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

V. CONTACTS

Pre-Implementation Contact(s): Sumita Sen, 410-786-5755, sumita.sen@cms.hhs.gov

Post-Implementation Contact(s): Sumita Sen, 410-786-5755, sumita.sen@cms.hhs.gov

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Carriers, and Regional Home Health Carriers (RHHIs)*:

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

Section B: *For Medicare Administrative Contractors (MACs)*:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.