CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services**
Transmittal 1674	**Date: JANUARY 30, 2009**
	Change Request 6336

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 6229. This CR also instructs Shared System Maintainers (SSMs) to deactivate the codes that have been deactivated since CR 6229, and instructs SSMs and CEDI to accept deactivated codes in derivitive messages. Additionally this CR instructs VIPs to update Medicare Remit Easy Print (MREP). This Recurring Update Notification applies to Chapter 22, Section 60.1.

NEW / REVISED MATERIAL
**EFFECTIVE DATE: ***April 1, 2009
IMPLEMENTATION DATE: April 6, 2009

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: 1674	Date: January 30, 2009	Change Request:6336

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

EFFECTIVE DATE: April 1, 2009

IMPLEMENTATION DATE: April 6, 2009

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 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 transaction.

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 which 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 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 may not align with the Medicare release schedule. Please 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 and/or remark code past the deactivation date whether the deactivation is requested by Medicare or any other entity. The regular code update CR will establish the implementation date for Medicare contractors and the Shared System Maintainers if no other specific CR has been issued by another CMS component. 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. Lists of all deactivated and scheduled to be deactivated CARCs and RARCs are available at the WPC Web site:

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

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

The new codes become effective when approved. Any modification or deactivation becomes effective on April 1 or July 1 or October 1 or January 1. The effective date for a modification may also be the date when it's approved if the requester can provide enough justification to have the modification become effective earlier than the next quarterly release date. The committee that maintains the CARC list has recently made a decision that any deactivation or modification (see above for exception scenario) will match the quarterly release effective dates rather than strict 6 months from the approval date to avoid any issue for payers (e.g., Medicare) that can implement any change only at the start of a quarter.

New Codes - CARC:

Code	Current Narrative	Effective Date
226	Information requested from the Billing/Rendering Provider was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason code.)	9/21/2008
227	Information requested from the patient/insured/responsible party was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	9/21/2008
228	Denied for failure of this provider, another provider or the subscriber to supply requested information to a previous payer for their adjudication	9/21/2008

Modified Codes - CARC

Code	Current Modified Narrative	Effective Date
148	Information from another provider was not provided or was insufficient/incomplete. This change effective 7/1/2009: Information from another provider was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	7/1/2009

Deactivated Codes - CARC

Code	Current Narrative	Effective Date
17	Requested information was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	7/1/2009
B18	This procedure code and modifier were invalid on the date of service.	3/1/2009

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 entities 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 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 (both CARC and RARC) 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. Medicare contractors shall not use any deactivated reason and/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

RARC list is updated 3 times a year – in early March, July, and November although the Committee meets every month. The RARC Committee has established the following schedule:

Request received in October – January:

Published in early March.

Deactivation becomes effective in October

Any new code or modification become effective when published

Request received in February – May:

Published in early July

Deactivation becomes effective in January

Any new code or modification become effective when published

Request received in June – September:

Published in early November

Deactivation becomes effective in April

Any new code or any modification becomes effective when published

The Centers for Medicare and Medicaid Services (CMS) will publish the recurring code update CR 4 times a year with implementation in January, April, July and October. As mentioned earlier, specific CMS

components may publish additional CRs instructing contractors to use specific RARCs and establishing implementation date that may differ from the implementation date mentioned in the recurring code update CR. If there is any difference in the implementation dates, the contractors are to implement on the earlier date of the two.

By April 6, 2009 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 (SPR) 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 codes. At this site you can find some other information that is also available from the WPC Web site. The 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 a monetary adjustment. Codes that are "Informational" will have "Alert" in the text to identify them as informational rather than explanatory codes These "Informational" codes may be used without any CARC explaining a specific 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 when a RARC is required with a CARC -16, 17, 96, 125, and A1.

NOTE III: This recurring CR lists only the changes that have been approved since the last code update CR, and does not provide a complete list of modified or deactivated codes. You must get the complete list for both CARC and RARC from the WPC web site.

New Codes - RARC:

Code	Current Narrative	Medicare Initiated
N505	**Alert:** This response includes only services that could be estimated in real time. No estimate will be provided for the services that could not be estimated in real time.	NO
N506	**Alert:** This is an estimate of the member's liability based on the information available at the time the estimate was processed. Actual coverage and member liability amounts will be determined when the claim is processed. This is not a pre-authorization or a guarantee of payment.	NO
N507	Plan distance requirements have not been met.	NO
N508	Alert: This real time claim adjudication response represents the member responsibility to the provider for services reported. The member will receive an Explanation of Benefits electronically or in the mail. Contact the insurer if there are any questions.	NO

N509	Alert: A current inquiry shows the member's Consumer Spending Account contains sufficient funds to cover the member liability for this claim/service. Actual payment from the Consumer Spending Account will depend on the availability of funds and determination of eligible services at the time of payment processing.	NO
N510	Alert: A current inquiry shows the member's Consumer Spending Account does not contain sufficient funds to cover the member's liability for this claim/service. Actual payment from the Consumer Spending Account will depend on the availability of funds and determination of eligible services at the time of payment processing.	NO
N511	Alert: Information on the availability of Consumer Spending Account funds to cover the member liability on this claim/service is not available at this time.	NO
N512	Alert: This is the initial remit of a non-NCPDP claim originally submitted real-time without change to the adjudication.	NO
N513	Alert: This is the initial remit of a non-NCPDP claim originally submitted real-time with a change to the adjudication.	NO
N514	Consult plan benefit documents/guidelines for information about restrictions for this service.	YES
N515	Alert: Submit this claim to the patient's other insurer for potential payment of supplemental benefits. We did not forward the claim information.	YES

There was no modification or deactivation for RARC in this time period (June 08 – September 08).

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 shall report only currently valid codes in both the remittance advice and COB Claim transaction. 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

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)						
		A/B	DME	FI	CAR	RHH	Shared-System Maintainers	OTHER CEDI

							FISS	MCS	VMS	CWF	
6336.1	A/B MACs, carriers, DME MACs, FIs, and RHHIs shall update reason and remark codes that have been modified and apply to Medicare by April 6, 2009.	X	X	X	X	X					
6336.2	A/B MACs, carriers, DME MACs, FIs, and RHHIs shall update reason and remark codes to include new codes that apply to Medicare by April 6, 2009.	X	X	X	X	X					
6336.3	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 April 6, 2009.						X	X	X		
6336.4	FISS, MCS, and CEDI shall make necessary programming changes by April 6, 2009, so that deactivated reason and remark codes are allowed in derivative messages even after the deactivation effective date when: ● Medicare is not primary; and ● 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			X
6336.5	FISS, MCS, and VMS shall make necessary programming changes by April 6, 2009, so that deactivated reason and remark codes are allowed in derivative messages even after the deactivation effective 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		
6336.6	VMS shall update the Medicare Remit Easy Print (MREP) 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 since April, 2008.)								X		
6336.7	VMS shall update the Medicare Remit Easy Print (MREP) software to include 3 fixes listed below: #30903 - Appendix A of the MREP User Manual requires an update. The Remittance Advice Field needs to be updated so that the field "Provider Adjustment details: FCN" is updated to "Provider Adjustment details:								X		

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER CEDI
							FISS	MCS	VMS	CWF	
	FCN/Other Identifier". #30904 - The "Display Claim" option within the MREP software is not available after selecting the "Check All" function. MREP will be updated so that the "Display Claim" option is available after selecting the "Check All" function. #30905 - When one or more claims within a Remit are selected within the MREP software, and the "Uncheck All" function is invoked the "Display Claim" option is available when claims are not checked. When the "Display Claim" function is invoked, a blank box appears. MREP will be updated to ensure the "Display Claim" option is not available when there are no claims selected in the Claim List tab.										
6336.8	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 updated MREP software.	X	X		X						
6336.9	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, 226, 227, 228, 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 generic CARCs.	X	X	X	X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B	DME	FI	CAR	RHH	Shared-System Maintainers				OTHER CEDI

							FISS	MCS	VMS	CWF	
6336.10	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: For any recommendations and supporting information associated with listed requirements, use the box below: N/A

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

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

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.