CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2618	**Date: December 21, 2012**
	Change Request 8154

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: April 1, 2013
IMPLEMENTATION DATE: April 1, 2013

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 Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

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: 2618	Date: December 21, 2012	Change Request: 8154

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

EFFECTIVE DATE: April 1, 2013
IMPLEMENTATION DATE: April 1, 2013

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 8029, Transmittal 2521, issued on August 17, 2012), 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 or four 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 becomes effective at a future date, contractors must make sure that they update on 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 prioratizes the requests. In order to follow the CMS release schedule, the cut off dates are July 31 to receive requests, and August 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

Use "Shall" to denote a mandatory requirement.

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
8154.1	Contractors shall update reason and remark codes that have been modified and apply to Medicare by April 1, 2013 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	X	X					
8154.2	Contractors shall update reason and remark codes to include new codes that apply to Medicare by April 1, 2013, if and as instructed by CMS. See Attachment I and II for CARC and RARC changes respectively since CR 8029. **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	X	X	X	X	X	X					

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
	by CMS.											
8154.3	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 1, 2013. **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		
8154.4	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 1, 2013.							X	X	X		
8154.5	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
8154.6	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		
8154.7	VMS shall update the Medicare Remit Easy Print (MREP) software by April 1, 2013. This update shall be based on the CARC and RARC lists as posted on WPC Web site on November 1, 2012.									X		

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
	NOTE: This update is provided in a separate file since April, 2008.											
8154.8	FISS shall update the PC Print software by April 1, 2013. This update shall be based on the CARC and RARC lists as posted on WPC Web site on November 1, 2012.							X				
8154.9	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			X						CEDI

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility						
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Other
		Part A	Part B					
8154.10	MLN Article : 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 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	X	

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A
Use "Should" to denote 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) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with 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 do 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 8154
ATTACHMENT I
New Codes – CARC:

Code	Code Narrative	Effective Date
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.	9/30/2012
245	Provider performance program withhold.	9/30/2012
246	This non-payable code is for required reporting only.	9/30/2012
247	Deductible for Professional service rendered in an Institutional setting and billed on an Institutional claim. *Notes: For Medicare Bundled Payment use only, under the Patient Protection and Affordable Care Act (PPACA).*	9/30/2012
248	Coinsurance for Professional service rendered in an Institutional setting and billed on an Institutional claim. *Notes: For Medicare Bundled Payment use only, under the Patient Protection and Affordable Care Act (PPACA).*	9/30/2012
249	This claim has been identified as a readmission. (Use only with Group Code CO)	9/30/2012
250	The attachment content received is inconsistent with the expected content.	9/30/2012
251	The attachment content received did not contain the content required to process this claim or service	9/30/2012
252	An attachment is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	9/30/2012
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.	9/30/2012
W4	Workers' Compensation Medical Treatment Guideline Adjustment.	9/30/2012
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') 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 P&C Auto only. Start: 09/30/2012	9/30/2012
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	9/30/2012

	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 P&C Auto only. Start: 09/30/2012	
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). To be used for P&C Auto only.	9/30/2012

Modified Codes – CARC:

Code	Modified Narrative	Effective Date
18	Duplicate claim/service. This change effective 1/1/2013: Exact duplicate claim/service (Use only with Group Code OA)	1/1/2013
23	The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA)	9/30/2012
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability). This change effective 7/1/2013: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability)	9/30/2012
133	The disposition of the claim/service is pending further review. This change effective 1/1/2013: The disposition of the claim/service is pending further review. (Use only with Group Code OA)	9/30/2012
136	Failure to follow prior payer's coverage rules. (Use Group Code OA). This change effective 7/1/2013: Failure to follow prior payer's coverage rules. (Use only with Group Code OA)	
173	Service was not prescribed by a physician. This change effective 7/1/2013: Service/equipment was not prescribed by a physician.	
201	Workers' Compensation case settled. Patient is responsible for amount of this claim/service through WC 'Medicare set aside arrangement' or other agreement. (Use group code PR). This change effective 7/1/2013: 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)	7/1/2013
209	Per regulatory or other agreement. The provider cannot	7/1/2013

	collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to patient if collected. (Use Group code OA) This change effective 7/1/2013: Per regulatory or other agreement. The provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to patient if collected. (Use only with Group code OA)	
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)	9/30/2012
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)	9/30/2012
221	Workers' Compensation 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). This change effective 7/1/2013: 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)	9/30/2012
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 NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) This change effective 7/1/2013: Information requested from the Billing/Rendering Provider was not provided or not provided timely or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	7/1/2013
229	Partial charge amount not considered by Medicare due to the initial claim Type of Bill being 12X. Note: This code can only be used in the 837 transaction to convey Coordination of Benefits information when the secondary payer's cost avoidance policy allows providers to bypass claim submission to a prior payer. Use Group Code PR. This change effective 7/1/2013: Partial charge amount not considered by Medicare due to the initial claim Type of Bill being 12X. Note: This code can only be used in the	7/1/2013

	837 transaction to convey Coordination of Benefits information when the secondary payer's cost avoidance policy allows providers to bypass claim submission to a prior payer. (Use only with Group Code PR)	
236	This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative. This change effective 7/1/2013: This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/ fee schedule requirements.	7/1/2013
238	Claim spans eligible and ineligible periods of coverage, this is the reduction for the ineligible period (use Group Code PR). This change effective 7/1/2013: Claim spans eligible and ineligible periods of coverage, this is the reduction for the ineligible period. (Use only with Group Code PR)	7/1/2013

Deactivated Codes – CARC: None

These are changes in the CARC database since the last code update CR 8029. The full CARC list must be downloaded from the WPC website:
http://wpc-edi.com/Reference

CR 8154
ATTACHMENT II
New Codes – RARC:

Code	Code Narrative	Effective Date
N560	The pilot program requires an interim or final claim within 60 days of the Notice of Admission. A claim was not received.	11/1/2012
N561	The bundled claim originally submitted for this episode of care includes related readmissions. You may resubmit the original claim to receive a corrected payment based on this readmission.	11/1/2012
N562	The provider number of your incoming claim does not match the provider number on the processed Notice of Admission (NOA) for this bundled payment.	11/1/2012
N563	Missing required provider/supplier issuance of advance patient notice of non-coverage. The patient is not liable for payment for this service.	11/1/2012
N564	Patient did not meet the inclusion criteria for the demonstration project or pilot program.	11/1/2012
N565	Alert: This procedure code requires a modifier. Future claims containing this procedure code must include an appropriate modifier for the claim to be processed.	11/1/2012
N566	Alert: This procedure code requires functional reporting. Future claims containing this procedure code must include an applicable non-payable code and appropriate modifiers for the claim to be processed.	11/1/2012

Modified Codes – RARC:

Code	Modified Narrative	Effective Date
M39	The patient is not liable for payment for this service as the advance notice of non-coverage you provided the patient did not comply with program requirements. The Note: (Modified 2/1/04, 4/1/07, 11/1/09) Related to N563	11/1/2012
M137	Part B coinsurance under a demonstration project or pilot program.	11/1/2012

Deactivated Codes – RARC:

Code	Narrative	Effective Date
N553	Payment adjusted based on a Low Income Subsidy (LIS) retroactive coverage or status change.	11/1/2012

These are changes in the RARC database since the last code update CR 7775. The full RARC list must be downloaded from the WPC website:
http://wpc-edi.com/Reference