CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 859

Department of Health & Human Services (DHHS)

Centers for Medicare & Medicaid Services (CMS)

Date: FEBRUARY 17, 2006

Change Request 4314

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

I. SUMMARY OF CHANGES: This Change Request instructs Medicare contractors and ViPs to update and use the most recent valid remark and reason codes in their electronic and paper remittance advice, coordination of benefit transactions, and Medicare Remit Easy Print software.

NEW/REVISED MATERIAL
EFFECTIVE DATE: *April 01, 2006
IMPLEMENTATION DATE: April 03, 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: 859	Date: February 17, 2006	Change Request 4314

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.

Traditionally, remark code changes that impact Medicare are requested by Medicare 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 Medicare 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 otherwise instructed by Medicare. 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

NOTE: 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.

The list is updated 3 times a year. By April 3, 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 July 1, 2005 to October 30, 2005.

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
N357	Time frame requirements between this service/procedure/supply and a related service/procedure/supply have not been met.	Y
N358	This decision may be reviewed if additional documentation as described in the contract or plan benefit documents is submitted.	N
N359	Missing/incomplete/invalid height.	N
N360	Coordination of benefits has not been calculated when estimating benefits for this pre-determination. Submit payment information from the primary payer with the secondary claim.	N
N361	Charges are adjusted based on multiple diagnostic imaging procedure rules.	N

N362	The number of Days or Units of Service exceeds our acceptable maximum.	N
N363	Alert: in the near future we are implementing new policies/procedures that would affect this determination.	N
N364	According to our agreement, you must waive the deductible and/or coinsurance amounts.	Y

Modified Codes

Code	Current Modified Narrative	Modification Date
M16	Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision.	Modified eff. 11/18/05
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 (*)
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.	Modified eff. 11/18/05 (**)
N9	Adjustment represents the estimated amount a previous payer may pay.	Modified eff. 11/18/05
N34	Incorrect claim form/format for this service.	Modified eff. 11/18/05
N207	Missing/incomplete/invalid weight.	Modified eff. 11/18/05

N355	The law permits exceptions to the refund requirement in two cases: - If you did not know, and could not have reasonably been expected to know, that we would not pay for this service; or - If you notified the patient in writing before providing the service that you believed that we were likely to deny the service, and the patient signed a statement agreeing to pay for the service. If you come within either exception, or if you believe the carrier was wrong in its determination that we do not pay for this service, you should request appeal of this determination within 30 days of the date of this notice. Your request for review should include any additional information necessary to support your position. If you request an appeal within 30 days of receiving this notice, you may delay refunding the amount to the patient until you receive the results of the review. If the review decision is favorable to you, you do not need to make any refund. If, however, the review is unfavorable, the law specifies that you must make the refund within 15 days of receiving the unfavorable review decision. The law also permits you to request an appeal at any time within 120 days of the date you receive this notice. However, an appeal request that is received more than 30 days after the date of this notice, does not permit you to delay making the refund. Regardless of when a review is requested, the patient will be notified that you have requested one, and will receive a copy of the determination. The patient has received a separate notice of this denial decision. The notice advises that he/she may be entitled to a refund of any amounts paid, if you should have known that we would not pay and did not tell him/her. It also instructs the patient to contact our office if he/she does not hear anything about a refund within 30 days.	Modified eff. 11/18/05

* This modification shall be implemented effective January 1, 2006, and has been communicated in a separate instruction (CR 4326).

** Medicare contractors shall not use MA03 effective from January 1, 2006, and has been communicated in a separate instruction (CR 4326) .

Deactivated Codes

M78	Missing/incomplete/invalid HCPCS modifier.	Deactivated effective 5/18/06, consider using Reason Code 4

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 September 2005 are listed here. By April 3, 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 are effective for a specified future and succeeding versions, but contractors can also 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 specified in the Washington Publishing Company (WPC) posting. The committee approved the following reason code changes in September 2005.

Reason Code Changes

New Codes

Code	Current Narrative	Notes
190	Payment is included in the allowance for a Skilled Nursing Facility (SNF) qualified stay.	New as of 10/05

191	Claim denied because this is not a work related injury/illness and thus not the liability of the workers' compensation carrier.	New as of 10/05
192 (*)	Non standard adjustment code from paper remittance advice.	New as of 10/05

* This new code was created at the request of Medicare because:
1) providers who do not qualify for Administrative Simplification Compliance Act (ASCA) exemption must submit claims electronically;
2) if Medicare is secondary, and the primary payer has sent a paper RA with proprietary code(s), the provider could not send a compliant electronic claim unless a crosswalk between the payer proprietary codes and the standard CARC is available.

In CR 4123 contractors were instructed to complete entry of 192 as a valid code, and accept claims containing this code for adjudication. Contractors must encourage providers to utilize this code, and submit COB claims electronically.

Modified Codes

Code	Current Modified Narrative	Notes
182	Payment adjusted because the procedure modifier was invalid on the date of service.	Modified 8/8/05
B18	Payment adjusted because this procedure code and modifier were invalid on the date of service.	Modified 8/8/05

Retired Codes

Code	Current Narrative	Notes
52	The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.	Inactive as of 2/1/06
B17	Payment adjusted because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current.	Inactive as of 2/1/06

In September, CMS requested two new codes to be used in lieu of current reason codes 1 ("Deductible") and 2 ("Coinsurance Amount") when a provider is not allowed to collect any deductible and/or any coinsurance. Section 630 of the Medicare Modernization Act (MMA) permits Indian Health Service (IHS) facilities to directly bill Medicare for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). Federal government agencies do not permit providers to collect coinsurance or deductible payments from IHS patients.

The committee did not approve CMS request for new codes, but suggested that reason codes 1 and 2 should be used with Group Code CO (Contractual Obligation) instead of PR (Patient Responsibility). Currently in most situations Group Code PR is used with reason codes 1 and 2. Contractors must use Group code CO under this special situation with codes 1 and 2 (see related CR 3845).

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	
4314.1.1	Intermediaries/RHHIs/Carriers/DMERCs and VMS shall update reason and remark codes that have been modified and apply to Medicare by April 3, 2006.	X	X	X	X			X		
4314.1.2	Intermediaries/RHHIs/Carriers/DMERCs and VMS shall update reason and remark codes to include new codes that apply to Medicare by April 3, 2006.	X	X	X	X			X		
4314.1.3	Intermediaries/RHHIs/Carriers/DMERCs and VMS shall update reason and remark codes that have been deactivated whether they apply to Medicare or not by April 3, 2006.	X	X	X	X			X		
4314.2	VMS shall update the Medicare Remit Easy Print software to include the most current CARC and RARC lists available from the following Web site:							X		

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	http://www.wpc-edi.com/codes									

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	
4314.3	A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn 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 Medlearn 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*: April 1, 2006 **Implementation Date:** April 3, 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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