



**News Flash - Effective January 1, 2008, National Provider Identifiers (NPIs) will be required to identify the primary providers (the Billing and Pay-to Providers) in Medicare electronic and paper institutional claims (i.e. 837I and UB-04 claims). You may continue to use the legacy identifier in these fields as long as you also use the NPI in these fields. This means that 837I and UB-04 claims with ONLY legacy identifiers in the Billing and Pay-to Provider fields will be rejected starting on January 1, 2008. (Pay-to Provider is identified only if it is different from the Billing Provider.) You may continue to use only legacy identifiers for the secondary provider fields in the 837I and UB-04 claims until May 23, 2008, if you choose.**

MLN Matters Number: MM5800

Related Change Request (CR) #: 5800

Related CR Release Date: November 30, 2007

Effective Date: January 1, 2008

Related CR Transmittal #: R1384CP

Implementation Date: January 7, 2008

**Note:** This article was updated on September 25, 2012, to reflect current Web addresses. All other information remains the same.

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

### Provider Types Affected

Physicians, providers, and suppliers who submit claims to Medicare contractors (carriers, fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), Part A/B Medicare Administrative Contractors (A/B MACs), and Durable Medical Equipment Medicare Administrative Contractors (DME MACs)) for services.

### Impact on Providers

CR 5800, from which this article is taken, announces the latest update of Remittance Advice Remark Codes used in electronic and paper remittance advice and Claim Adjustment Reason Codes used in electronic and paper remittance advice and coordination of benefits (COB) claim transactions. These changes will be effective January 1, 2008. Be sure billing staff are aware of these changes.

#### Disclaimer

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## Background

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Two code sets—the reason and remark code sets—must be used to report payment adjustments in remittance advice transactions. The reason codes are also used in some coordination-of-benefits transactions.

The remittance advice remark code list is maintained by the Centers for Medicare & Medicaid Service (CMS), and used by all payers; and additions, deactivations, and modifications to it may be initiated by both Medicare and non-Medicare entities. The health care claim adjustment reason code list is maintained by a national Code Maintenance committee that meets when X12 meets for their trimester meetings to make decisions about additions, modifications, and retirement of existing reason codes.

Both code lists are updated three times a year, and are posted at <http://wpc-edi.com/codes> on the Internet. The lists at the end of this article summarize the latest changes to the remark code lists, as announced in CR 5800, effective on January 1, 2008. As a reminder, CMS notes that the claim adjustment reason code of A2 (Contractual adjustment) is deactivated effective January 1, 2008.

CMS has developed a new website 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 Washington Publishing Company (WPC) website. The new website address is <http://www.cmsremarkcodes.info/> on the Internet.

Note that this website does not replace the Washington Publishing Company (WPC) site and, should there be any discrepancies between this site and the WPC site, consider the WPC site to be correct.

## Additional Information

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You may see the official instruction (CR5800) issued to your Medicare Carrier, A/B MAC, FI, DME MAC or RHHI by going to <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1384CP.pdf> on the CMS website.

If you have questions, please contact your Medicare A/B MAC, carrier, FI, DME MAC or RHHI at their toll-free number which may be found at: <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

For additional information about Remittance Advice, please refer to *Understanding the Remittance Advice (RA): A Guide for Medicare Providers, Physicians, Suppliers, and Billers* at: [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/RA\\_Guide\\_Full\\_03-22-06.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf) on the CMS website.

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## Remittance Advice Remark Code Changes

### New Codes

Code	Current Narrative	Comment
N388	Missing/incomplete/invalid prescription number. <b>Note: (New Code 8/1/07)</b>	Medicare initiated
N389	Duplicate prescription number submitted. <b>Note: (New Code 8/1/07)</b>	Medicare initiated
N390	This service cannot be billed separately. <b>Note: (New Code 8/1/07)</b>	Medicare initiated
N391	Missing emergency department records. <b>Note: (New Code 8/1/07)</b>	Not Medicare initiated
N392	Incomplete/invalid emergency department records. <b>Note: (New Code 8/1/07)</b>	Not Medicare initiated
N393	Missing progress notes or report. <b>Note: (New Code 8/1/07)</b>	Not Medicare initiated
N394	Incomplete/invalid progress notes or report. <b>Note: (New Code 8/1/07)</b>	Not Medicare initiated
N395	Missing laboratory report. <b>Note: (New Code 8/1/07)</b>	Not Medicare initiated
N396	Incomplete/invalid laboratory report. <b>Note: (New Code 8/1/07)</b>	Not Medicare initiated
N397	Benefits are not available for incomplete service(s)/undelivered item(s). <b>Note: (New Code 8/1/07)</b>	Not Medicare initiated
N398	Missing elective consent form. <b>Note: (New Code 8/1/07)</b>	Not Medicare initiated
N399	Incomplete/invalid elective consent form. <b>Note: (New Code 8/1/07)</b>	Not Medicare initiated
N400	Alert: Electronically enabled providers should submit claims electronically. <b>Note: (New Code 8/1/07)</b>	Not Medicare initiated
N401	Missing periodontal charting. <b>Note: (New Code 8/1/07)</b>	Not Medicare initiated
N402	Incomplete/invalid periodontal charting. <b>Note: (New Code 8/1/07)</b>	Not Medicare initiated

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Code	Current Narrative	Comment
N403	Missing facility certification. <b>Note: (New Code 8/1/07)</b>	Not Medicare initiated
N404	Incomplete/invalid facility certification. <b>Note: (New Code 8/1/07)</b>	Not Medicare initiated
N405	This service is only covered when the donor's insurer(s) do not provide coverage for the service. <b>Note: (New Code 8/1/07)</b>	Not Medicare initiated
N406	This service is only covered when the recipient's insurer(s) do not provide coverage for the service. <b>Note: (New Code 8/1/07)</b>	Not Medicare initiated
N407	You are not an approved submitter for this transmission format. <b>Note: (New Code 8/1/07)</b>	Medicare Initiated
N408	This payer does not cover deductibles assessed by a previous payer. <b>Note: (New Code 8/1/07)</b>	Not Medicare initiated
N409	This service is related to an accidental injury and is not covered unless provided within a specific time frame from the date of the accident. <b>Note: (New Code 8/1/07)</b>	Not Medicare initiated
N410	This is not covered unless the prescription changes. <b>Note: (New Code 8/1/07)</b>	Not Medicare initiated
N411	This service is allowed one time in a 6-month period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.) <b>Note: (New Code 8/1/07)</b>	Not Medicare initiated
N412	This service is allowed 2 times in a 12-month period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.) <b>Note: (New Code 8/1/07)</b>	Not Medicare initiated
N413	This service is allowed 2 times in a benefit year. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.) <b>Note: (New Code 8/1/07)</b>	Not Medicare initiated
N414	This service is allowed 4 times in a 12-month period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.) <b>Note: (New Code 8/1/07)</b>	Not Medicare initiated

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Code	Current Narrative	Comment
N415	This service is allowed 1 time in an 18-month period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.) <b>Note: (New Code 8/1/07)</b>	Not Medicare initiated
N416	This service is allowed 1 time in a 3-year period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.) <b>Note: (New Code 8/1/07)</b>	Not Medicare initiated
N417	This service is allowed 1 time in a 5-year period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.) <b>Note: (New Code 8/1/07)</b>	Not Medicare initiated
N418	Misrouted claim. See the payer's claim submission instructions. <b>Note: (New Code 8/1/07)</b>	Not Medicare initiated
N419	Claim payment was the result of a payer's retroactive adjustment due to a retroactive rate change. <b>Note: (New Code 8/1/07)</b>	Not Medicare initiated
N420	Claim payment was the result of a payer's retroactive adjustment due to a Coordination of Benefits or Third Party Liability Recovery. <b>Note: (New Code 8/1/07)</b>	Not Medicare initiated
N421	Claim payment was the result of a payer's retroactive adjustment due to a Peer Review Organization decision. <b>Note: (New Code 8/1/07)</b>	Not Medicare initiated
N422	Claim payment was the result of a payer's retroactive adjustment due to a payer's contract incentive program. <b>Note: (New Code 8/1/07)</b>	Not Medicare initiated
N423	Claim payment was the result of a payer's retroactive adjustment due to a non standard program. <b>Note: (New Code 8/1/07)</b>	Not Medicare initiated
N424	Patient does not reside in the geographic area required for this type of payment. <b>Note: (New Code 8/1/07)</b>	Medicare initiated
N425	Statutorily excluded service(s). <b>Note: (New Code 8/1/07)</b>	Medicare initiated
N426	No coverage when self-administered. <b>Note: (New Code 8/1/07)</b>	Medicare initiated
N427	Payment for eyeglasses or contact lenses can be made only after cataract surgery.	Medicare initiated

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Code	Current Narrative	Comment
	<b>Note: (New Code 8/1/07)</b>	
N428	Service/procedure not covered when performed in this place of service. <b>Note: (New Code 8/1/07)</b>	Medicare initiated
N429	This is not covered since it is considered routine. <b>Note: (New Code 8/1/07)</b>	Medicare initiated

**\*NOTE:** Some remark codes may provide only information. They may not necessarily supplement the explanation provided through a reason code, or, 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. For example, this informational code is sent per state regulation, but does not explain any adjustment:

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

These informational codes will be used only if specific information needs to be communicated but not as default codes

### Modified Codes

Code	Current Modified Narrative	Comment
M27	<b>Alert:</b> The patient has been relieved of liability of payment of these items and services under the limitation of liability provision of the law. The provider is ultimately liable for the patient's waived charges, including any charges for coinsurance, since the items or services were not reasonable and necessary or constituted custodial care, and you knew or could reasonably have been expected to know, that they were not covered. You may appeal this determination. You may ask for an appeal regarding both the coverage determination and the issue of whether you exercised due care. The appeal request must be filed within 120 days of the date you receive this notice. You must make the request through this office.	Modified 10/1/02, 8/1/05, 4/1/07, 8/1/07

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Code	Current Modified Narrative	Comment
M70	<b>Alert:</b> The patient is a member of an employer-sponsored prepaid health plan. Services from outside that health plan are not covered. However, as you were not previously notified of this, we are paying this time. In the future, we will not pay you for non-plan services.	Modified 4/1/07, 8/1/07
MA14	<b>Alert:</b> The patient is a member of an employer-sponsored prepaid health plan. Services from outside that health plan are not covered. However, as you were not previously notified of this, we are paying this time. In the future, we will not pay you for non-plan services.	Modified 4/1/07, 8/1/07
M62	<b>Alert:</b> This is a telephone review decision.	Modified 4/1/07, 8/1/07
N12	Policy provides coverage supplemental to Medicare. As the member does not appear to be enrolled in the applicable part of Medicare, the member is responsible for payment of the portion of the charge that would have been covered by Medicare.)	Modified 8/1/07
N84	<b>Alert:</b> Further installment payments are forthcoming.	Modified 4/1/07, 8/1/07
N85	<b>Alert:</b> This is the final installment payment.	Modified 4/1/07, 8/1/07
N129	Not eligible due to the patient's age.	New Code 10/31/02, Modified 8/1/07

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