



**News Flash** - The Office of the Inspector General in the Department of Health and Human Services has issued a policy statement that assures Medicare providers, practitioners, and suppliers affected by retroactive increases in payment rates under the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 that they will not be subject to OIG administrative sanctions if they waive retroactive beneficiary cost-sharing amounts attributable to those increased payment rates, subject to the conditions noted in the policy statement. To view the document, go to [http://oig.hhs.gov/fraud/docs/alertsandbulletins/2008/MIPPA\\_Policy\\_Statement.PDF](http://oig.hhs.gov/fraud/docs/alertsandbulletins/2008/MIPPA_Policy_Statement.PDF) on the Internet.

MLN Matters Number: MM6109 **Revised**

Related Change Request (CR) #: 6109

Related CR Release Date: July 25, 2008

Effective Date: October 1, 2008

Related CR Transmittal #: R1563CP

Implementation Date: October 6, 2008

## Remittance Advice Remark Code and Claim Adjustment Reason Code Update

**Note:** This article was revised on June 23, 2010, to delete reference to a website that is no longer available. All other information is the same.

### 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 6109, from which this article is taken, announces the latest update of Remittance Advice Remark Codes (RARC) used in electronic and paper remittance advice, and Claim Adjustment Reason Codes (CARC) used in electronic and paper remittance advice and coordination of benefits (COB) claim transactions. These changes will be effective October 1, 2008.

#### Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

Be sure that your billing staffs are aware of these changes.

## 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 coordination-of-benefits (COB) transactions.

The RARC list is maintained by the Centers for Medicare & Medicaid Services (CMS), and used by all payers; and additions, deactivations, and modifications to it may be initiated by any health care organization. The CARC 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 on the Washington Publishing Company (WPC) website at <http://www.wpc-edi.com/Codes> on the Internet. The tables at the end of this article (right after the “Additional Information” section) summarize the latest changes to these lists, as announced in CR6109.

## Additional Information

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To see the official instruction (CR 6109) issued to your Medicare Carrier, RHHI, DME/MAC, FI and/or A/B MAC refer to <http://www.cms.hhs.gov/Transmittals/downloads/R1563CP.pdf> 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.hhs.gov/MLNProducts/downloads/RA\\_Guide\\_Full\\_03-22-06.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf) on the CMS website.

If you have questions, please contact your Medicare Carrier, RHHI, DME/MAC, FI and/or A/B MAC at their toll-free number which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website. The changes that are effective on October 1, 2008 are as follows:

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Remittance Advice Remark Code changesNew 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 |                   |               |

Health Care Claim Adjustment Reason CodesNew Codes

| Code | Current Narrative   | Effective Date (per WPC website) |
|------|---|----------------------------------|
| 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                        |

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| Code | Current Narrative  | Effective Date (per WPC website) |
|------|--|----------------------------------|
| 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. Please 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 website). |
|------|--|-----------------------------------|
| 151  | Payment adjusted because the payer deems the information submitted does not support this many/frequency of services. | 1/27/2008                         |

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Deactivated Codes

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