DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

News Flash –

CMS has instructed its contractors to delay turning on Phase 2 denial edits on the following claims to check for a valid individual National Provider Identifier (NPI) and to deny the claim when this information is missing:

- Medicare Part B **laboratory and imaging** claims and Durable Medical Equipment, Orthotics, and Supplies (DMEPOS) claims that require an ordering or referring physician/non-physician provider; and
- Part A Home Health Agency (HHA) claims that require an attending physician provider.

CMS will advise you of the new implementation date in the near future. In the interim, informational messages will continue to be sent for those claims that would have been denied had the edits been in place. See MLN Matters® Article SE1305 for more information.

MLN Matters® Number: MM8281 Revised

Related Change Request (CR) #: CR 8281

Related CR Release Date: April 12, 2013

Effective Date: July 1, 2013

Related CR Transmittal #: R2686CP

Implementation Date: July 1, 2013

Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP), and PC Print Update

Note: This article was revised on April 30, 2013, to revise the news flash (above) to show the Phase 2 edits are delayed. All other information remains the same.

Provider Types Affected

This MLN Matters® Article is intended for physicians, providers, and suppliers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),

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carriers, Durable Medical Equipment Medicare Administrative Contractors (DME MACs) and A/B MACs) for services to Medicare beneficiaries.

What You Need to Know

This article is based on Change Request (CR) 8281, which instructs Medicare contractors to make programming changes to incorporate updates to the Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) lists. It also instructs the Fiscal Intermediary Standard System (FISS) and the VIPs Medicare System (VMS) maintainers to update Medicare Remit Easy Print (MREP) and PC Print. Please make sure that your billing staffs are aware of these changes.

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 CARC and appropriate RARC 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 affect Medicare are usually requested by the Centers for Medicare & Medicaid Services (CMS) staff in conjunction with a policy change. If a modification has been initiated by an entity other than CMS for a code currently used by Medicare, 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.

CR8281 lists only the changes that have been approved since the last code update CR (CR8154, Transmittal 2618, issued on December 21, 2012, available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8154.pdf), and does not provide a complete list of codes for these two code sets.

Note: In case of any discrepancy in the code text as posted on Washington Publishing Company (WPC) website and as reported in any CR, the WPC version should be implemented.

Changes in CARC List Since CR8154

These are the changes in the CARC database since the last code update CR8154. The full CARC list must be downloaded from the WPC website, available at http://wpc-edi.com/Reference on the Internet.

New Codes – CARC: None

Modified Codes – CARC:

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Code	Modified Narrative	Effective Date
16	Claim/service lacks information which is needed for adjudication. 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 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s). 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. *Start: 01/01/1995 | Last Modified: 01/20/2013*	11/1/2013
18	Exact duplicate claim/service (Use only with Group Code OA) *Start: 01/01/1995 | Last Modified: 01/20/2013*	1/20/2013
49	These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. This change effective 11/1/2013: This is a non-covered service because it is a routine/preventive exam or a diagnostic/screening procedure done in conjunction with a routine/preventive exam. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. *Start: 01/01/1995 | Last Modified: 01/20/2013*	11/1/2013
133	The disposition of the claim/service is pending further review. (Use only with Group Code OA) *Start: 02/28/1997 | Last Modified: 01/20/2013*	1/20/2013

<u>Deactivated Codes – CARC</u>:

Code	Current Narrative	Effective Date
125	Submission/billing error(s). 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.) *Start: 01/01/1995 | Last Modified: 09/20/2009 | Stop: 11/01/2013*	11/1/2013

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Changes in RARC List Since CR8154

These are the changes in the RARC database since the last code update CR8154. The full RARC list must be downloaded from the WPC website, available at http://wpc-edi.com/Reference on the Internet.

New – RARC:

Code	Current Narrative	Effective Date
N567	Not covered when considered preventative. *Start: 03/01/2013*	3/1/2013
N568	Alert: Initial payment based on the Notice of Admission (NOA) under the Bundled Payment Model IV initiative. *Start: 03/01/2013*	3/1/2013
N569	Not covered when performed for the reported diagnosis. *Start: 03/01/2013*	3/1/2013
N570	Missing/incomplete/invalid credentialing data *Start: 03/01/2013*	3/1/2013
N571	Alert: Payment will be issued quarterly by another payer/contractor. *Start: 03/01/2013*	3/1/2013
N572	This procedure is not payable unless non-payable reporting codes and appropriate modifiers are submitted. *Start: 03/01/2013*	3/1/2013
N573	Alert: You have been overpaid and must refund the overpayment. The refund will be requested separately by another payer/contractor. *Start: 03/01/2013*	3/1/2013

Modified Codes – RARC:

Code	Current Narrative	Effective Date
N565	Alert: This non-payable reporting code requires a modifier. Future claims containing this non-payable reporting code must include an appropriate modifier for the claim to be processed. *Start: 11/01/2012 | Last Modified: 03/01/2013*	3/1/2013

Deactivated Codes – RARC: NONE

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Additional Information

The official instruction, CR8281, issued to your FI, RHHI, carrier, DME MAC, and A/B MAC regarding this change, may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2686CP.pdf on the CMS website.

If you have any questions, please contact your FI, RHHI, carrier, DME MAC, or A/B MAC 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.

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