DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

NEW product from the Medicare Learning Network® (MLN)

- "**Medicare Billing: 837I and Form CMS-1450**" Web-based Training (WBT)

MLN Matters® Number: MM8855 | **Related Change Request (CR) #: CR 8855**

Related CR Release Date: July 24, 2014 | **Effective Date: October 1, 2014**

Related CR Transmittal #: R2996CP | **Implementation Date: October 6, 2014**

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

Provider Types Affected

This MLN Matters® Article is intended for physicians, other providers, and suppliers who submit claims to Medicare Administrative Contractors (MACs), including Durable Medical Equipment (DME) MACs and Home Health & Hospice (HH&H) MACs, for services provided to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 8855 instructs the MACs to make programming changes to incorporate updates to the Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) lists. It also instructs Medicare system maintainers to update Medicare Remit Easy Print (MREP) and PC Print. Make sure that your billing staffs are aware of these changes and obtain the updated MREP or PC Print software if you use that software.

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.

For transaction 835 (Health Care Claim Payment/Advice) and standard paper remittance advice, there are two code sets, CARC and RARC, that must be used along with a 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 Coordination of Benefits (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.

MACs must make the necessary CARC/RARC code list updates on a regular basis. Any modification and/or deactivation, even if not initiated by Medicare, will be implemented.

The CARC and RARC changes that impact Medicare are usually requested by the Centers for Medicare & Medicaid Services (CMS) staff in conjunction with a policy change. MACs 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, MACs must either use the modified code or another code if the modification makes the modified code inappropriate to explain the specific reason for adjustment.

Medicare has 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. Medicare must be sure to not report any deactivated code on or before the effective date for deactivation as posted on the Washington Publishing Company (WPC) website. If any new or modified code has an effective date past the implementation date specified in CR8855, MACs must implement on the date specified on the WPC website.

The discrepancy between the dates may arise because the WPC website gets updated only three times a year and may not match the CMS release schedule. CR 8855 lists only the changes that have been approved since the last code update CR (CR 8703, Transmittal 2920, issued on April 4, 2014; see **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8703.pdf** on the CMS website), and does not provide a complete list of codes for these two code sets. The MACs

must get the complete list for both CARC and RARC from the WPC website 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 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.

You can find the WPC website, which has four listings available for both CARC and RARC, at **http://www.wpc-edi.com/Reference** on the Internet.

Changes in CARC List since CR 8703

The following tables list the changes in the CARC database since the last code update in CR8703. The full CARC list is available from the WPC website at **http://wpc-edi.com/Reference** on the Internet.

New Codes – CARC:

Code	Modified Narrative	Effective Date
261	The procedure or service is inconsistent with the patient's history.	06/01/2014

Modified Codes – CARC:

Code	Modified Narrative	Effective Date
201	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) *Notes: Not for use by Workers' Compensation payers; use code P3 instead.* ***CMS Note: This code was previously deactivated, however it is being reactivated.***	06/01/2014
250	The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing. At least one Remark Code must be provided (may be comprised of either the National Council of Prescription Drugs Programs (NCPDP) Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	06/01/2014

Code	Modified Narrative	Effective Date
251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. 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).	06/01/2014
257	The disposition of the claim/service is undetermined during the premium payment grace period, per Health Insurance Exchange requirements. This claim/service will be reversed and corrected when the grace period ends (due to premium payment or lack of premium payment). (Use only with Group Code OA) *Notes: To be used after the first month of the grace period.*	06/01/2014

Deactivated Codes – CARC: None

Changes in RARC List since CR 8703

The following tables list the changes in the RARC database since the last code update in CR8703. The full RARC list is available from the WPC website at **http://wpc-edi.com/Reference** on the Internet.

New Codes – RARC: None

Modified Codes – RARC:

Code	Modified Narrative	Effective Date
N572	This procedure is not payable unless appropriate non-payable reporting codes and associated modifiers are submitted.	07/01/2014
M77	Missing/incomplete/invalid/inappropriate place of service.	03/14/2014
M84	Medical code sets used must be the codes in effect at the time of service.	03/14/2014
MA100	Missing/incomplete/invalid date of current illness or symptoms.	03/14/2014
N202	Additional information/explanation will be sent separately.	03/14/2014
N203	Missing/incomplete/invalid anesthesia time/units.	03/14/2014
N205	Information provided was illegible.	03/14/2014

Code	Modified Narrative	Effective Date
N208	Missing/incomplete/invalid DRG code.	03/14/2014
N210	Alert: You may appeal this decision.	03/14/2014
N211	Alert: You may not appeal this decision.	03/14/2014
N212	Charges processed under a Point of Service benefit.	03/14/2014
N213	Missing/incomplete/invalid facility/discrete unit DRG/DRG exempt status information.	03/14/2014
N214	Missing/incomplete/invalid history of the related initial surgical procedure(s).	03/14/2014
N216	We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit package.	03/14/2014
N217	We pay only one site of service per provider per claim.	03/14/2014
N238	Incomplete/invalid physician certified plan of care.	03/14/2014
N245	Incomplete/invalid plan information for other insurance.	03/14/2014
N354	Incomplete/invalid invoice.	03/14/2014
N388	Missing/incomplete/invalid prescription number.	03/14/2014
N433	Resubmit this claim using only your National Provider Identifier (NPI).	03/14/2014
N438	This jurisdiction only accepts paper claims.	03/14/2014
N448	This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement.	03/14/2014
N467	Missing Tests and Analysis Report.	03/14/2014
N474	Incomplete/invalid certification.	03/14/2014
N476	Incomplete/invalid completed referral form.	03/14/2014
N478	Incomplete/invalid Dental Models.	03/14/2014
N482	Incomplete/invalid Models.	03/14/2014
N484	Incomplete/invalid Periodontal Charts.	03/14/2014
N488	Incomplete/invalid Prosthetics or Orthotics Certification.	03/14/2014
N490	Incomplete/invalid referral form.	03/14/2014
N543	Incomplete/invalid income verification.	03/14/2014

Code	Modified Narrative	Effective Date
N544	Alert: Although this was paid, you have billed with a referring/ordering provider that does not match our system record. Unless corrected this will not be paid in the future.	03/14/2014
N554	Missing/Incomplete/Invalid Family Planning Indicator.	03/14/2014
N570	Missing/incomplete/invalid credentialing data.	03/14/2014
N609	80% of the provider's billed amount is being recommended for payment according to Act 6.	03/14/2014
N645	Mark-up allowance.	03/14/2014
N667	Missing prescription.	03/14/2014
N668	Incomplete/invalid prescription.	03/14/2014
N687	Alert: This reversal is due to a retroactive disenrollment.	03/14/2014
N688	Alert: This reversal is due to a medical or utilization review decision.	03/14/2014
N689	Alert: This reversal is due to a retroactive rate change.	03/14/2014
N690	Alert: This reversal is due to a provider submitted appeal.	03/14/2014
N691	Alert: This reversal is due to a patient submitted appeal.	03/14/2014
N692	Alert: This reversal is due to an incorrect rate on the initial adjudication.	03/14/2014
N693	Alert: This reversal is due to a cancellation of the claim by the provider.	03/14/2014
N696	Alert: This reversal is due to a Coordination of Benefits or Third Party Liability Recovery retroactive adjustment.	03/14/2014
N697	Alert: This reversal is due to a payer's retroactive contract incentive program adjustment.	03/14/2014
N698	Alert: This reversal is due to non-payment of the Health Insurance Exchange premiums by the end of the premium payment grace period, resulting in loss of coverage.	03/14/2014
N704	Alert: You may not appeal this decision but can resubmit this claim/service with corrected information if warranted.	03/14/2014

Deactivated Codes – RARC: None

Additional Information

The official instruction, CR 8855 issued to your MAC regarding this change may be viewed at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2996CP.pdf** on the CMS website.

If you have any questions, please contact your MAC at their toll-free number. That number is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html** under - How Does It Work.