MLN Matters® — Information for Medicare Fee-For-Service Health Care Professionals

MLN Matters Number: MM4123 | Related Change Request (CR) #: 4123

Related CR Release Date: November 4, 2005 | Effective Date: January 1, 2006

Related CR Transmittal #: 743 | Implementation Date: January 3, 2006

Note: This article was updated on February 21, 2013, to reflect current Web addresses. All other information remains unchanged.

Remittance Advice Remark Code and Claim Adjustment Reason Code Update

Provider Types Affected

Physicians, providers, and suppliers who submit claims to Medicare contractors (carriers, fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), and durable medical equipment regional carriers (DMERCs)) for services

Provider Action Needed

STOP – Impact to You

The complete list of X12N 835 Health Care Remittance Advice Remark Codes and X12N 835 Health Care Claim Adjustment Reason Codes, including changes made from March 1, 2005 through June 30, 2005, can be found at *http://www.wpc-edi.com/codes*.

CAUTION – What You Need to Know

Please refer to the *Additional Information* section of this article for remark and reason code changes approved June 30, 2005.

GO – What You Need to Do

Be sure your staff is aware of these changes.

Background

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. Additions, deactivations, and modifications to the code list may be initiated by Medicare and non-Medicare entities. This list is updated three times a year, and posted at *http://wpc-edi.com/codes*.

The health care claim adjustment reason code list is maintained by a national Code Maintenance committee that meets three times a year when X12 meets for their trimester meetings to make decisions about additions, modifications, and retirement of existing reason codes. This updated list is posted three times per year.

Additional Information

The lists at the end of this article summarize changes made from March 1, 2005 through June 30, 2005.

In September, 2005, the Claim Adjustment Status Code Maintenance Committee approved a new reason code of 192 (Non-standard adjustment code from paper remittance advice), effective January 1, 2006. Reason Code 192 will be used by providers who must submit claims electronically under the Administrative Simplification Compliance Act when:

- Medicare is not the primary payer; and
- Providers have received paper remittance advice containing proprietary codes from the previous payer(s).

For additional information about Remittance Advice, please refer to *Understanding the Remittance Advice (RA): A Guide for Medicare Providers, Physicians, Suppliers, and Billers on the* CMS website.

The official instruction issued to your FI/carrier/DMERC/RHHI regarding this change may be found by going to http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R743CP.pdf on the CMS website.

If you have any questions, please contact your FI/carrier/DMERC/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.

Remittance Advice Remark Code Changes

Code	New/ Modified/ Deactivated /Retired	Current Narrative	Comment
N348	New	You chose that this service/supply/drug would be rendered/supplies and billed by a different practitioner/supplier.	Medicare Initiated
N349	New	The administration method and drug must be reported to adjudicate this service.	Not Medicare Initiated
N350	New	Missing/incomplete/invalid description of service for a Not Otherwise Classified (NOC) code or an Unlisted procedure.	Not Medicare Initiated
N351	New	Service date outside of the approved treatment plan service dates.	Not Medicare Initiated
N352	New	There are no scheduled payments for this service. Submit a claim for each patient visit.	Not Medicare Initiated
N353	New	Benefits have been estimated, when the actual services have been rendered, additional payment will be considered based on the submitted claim.	Not Medicare Initiated
N354	New	Incomplete/invalid invoice	Not Medicare Initiated
N355	New	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 review 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	Medicare Initiated

Code	New/ Modified/ Deactivated /Retired	Current Narrative	Comment
		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.	
N356	New	This service is not covered when performed with, or subsequent to, a non-covered service.	Not Medicare Initiated
N21	Modified	Your line item has been separated into multiple lines to expedite handling.	Modified effective August 1, 2005
M25	Modified	Payment has been adjusted because the information furnished does not substantiate the need for this level of service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this level of service, or if you notified the patient in writing in advance that we would not pay for this level of service and he/she agreed in writing to pay, ask us to review your claim within 120 days of the date of this notice. If you do not request an appeal, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her in excess of any deductible and coinsurance amounts. We will recover the reimbursement from you as an overpayment.	Modified effective August 1, 2005
M26	Modified	Payment has been adjusted because the information furnished does not substantiate the need for this level of service. If you have collected any amount from the patient for this level of service /any amount that exceeds the limiting charge for the less extensive service, the law requires you to refund that amount to the patient within 30 days of receiving this notice. The requirements for refund are in 1824(I) of the Social Security Act and 42CFR411.408. The section specifies that physicians who knowingly and willfully fail to make appropriate refunds may be subject to civil monetary penalties and/or exclusion from the program. If you have any questions about this notice, please contact this office.	Modified effective August 1, 2005
M27	Modified	The patient has been relieved of liability of payment of these items and services under the limitation of liability provision of the law. You, the provider, are 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 effective August 1, 2005
MA01	Modified	If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the appeal. However, in order to be eligible for an appeal, you must write to us within 120 days of the date you received this notice, unless you have a good reason for being late.	Modified effective August 1, 2005
MA02	Modified	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	Modified effective

Code	New/ Modified/ Deactivated /Retired	Current Narrative	Comment
		known that we would not pay and did not tell him/her. It also instructs the patient to contact your office if he/she does not hear anything about a refund within 30 days.	August 1, 2005
MA03	Modified	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. At the reconsideration, you must present any new evidence which could affect our decision.	Modified effective August 1, 2005
MA83	Modified	Did not indicate whether we are the primary or secondary payer.	Modified effective August 1, 2005
MA94	Modified	Did not enter the statement “Attending physician not hospice employee” on the claim form to certify that the rendering physician is not an employee of the hospice	Modified effective August 1, 2005
N122	Modified	Add-on code cannot be billed by itself.	Modified effective August 1, 2005
N125	Modified	Payment has been (denied for the/made only for a less extensive) service/item because the information furnished does not substantiate the need for the (more extensive) service/item. If you have collected any amount from the patient, you must refund that amount to the patient within 30 days of receiving this notice. The requirements for a refund are in §1834(a)(18) of the Social Security Act (and in §§1834(j)(4) and 1879(h) by cross-reference to §1834(a)(18)). Section 1834(a)(18)(B) specifies that suppliers which knowingly and willfully fail to make appropriate refunds may be subject to civil money penalties and/or exclusion from the Medicare program. If you have any questions about this notice, please contact this office.	Modified effective August 1, 2005
N29	Modified	Missing documentation/orders/notes/ summary/report/chart.	Modified effective August 1, 2005
N225	Modified	Modify N225 - Incomplete/invalid documentation/ orders/ notes/ summary/ report/chart.	Modified effective August 1, 2005
M23	Modified	Missing invoice.	Modified effective August 1, 2005

Reason Code Changes

Code	New/ Modified/ Deactivated /Retired	Current Narrative	Comment
167	New	This (these) diagnosis(es) is (are) not covered.	New as of June, 2005
168	New	Payment denied as Service(s) have been considered under the patient's medical plan. Benefits are not available under this dental plan.	New as of June, 2005
169	New	Payment adjusted because an alternate benefit has been provided.	New as of June, 2005
170	New	Payment is denied when performed/billed by this type of provider.	New as of June, 2005
171	New	Payment is denied when performed/billed by this type of provider in this type of facility.	New as of June, 2005
172	New	Payment is adjusted when performed/billed by a provider of this specialty.	New as of June, 2005
173	New	Payment adjusted because this service was not prescribed by a physician.	New as of June, 2005
174	New	Payment denied because this service was not prescribed prior to delivery.	New as of June, 2005
175	New	Payment denied because the prescription is incomplete.	New as of June, 2005
176	New	Payment denied because the prescription is not current.	New as of June, 2005
177	New	Payment denied because the patient has not met the required eligibility requirements.	New as of June, 2005
178	New	Payment adjusted because the patient has not met the required spend-down requirements.	New as of June, 2005
179	New	Payment adjusted because the patient has not met the required waiting requirements.	New as of June, 2005
180	New	Payment adjusted because the patient has not met the required residency requirements.	New as of June, 2005
181	New	Payment adjusted because this procedure code was invalid on the date of service.	New as of June, 2005
182	New	Payment adjusted because the procedure modifier was invalid on the date of service.	New as of June, 2005
183	New	The referring provider is not eligible to refer the service billed.	New as of June, 2005
184	New	The prescribing/ordering provider is not eligible to prescribe/order the service billed.	New as of June, 2005
185	New	The rendering provider is not eligible to perform the service billed.	New as of June, 2005
186	New	Payment adjusted since the level of care changed.	New as of June, 2005

Code	New/ Modified/ Deactivated /Retired	Current Narrative	Comment
187	New	Health Savings account payments	New as of June, 2005
188	New	This product/procedure is only covered when used according to FDA recommendations.	New as of June, 2005
189	New	"Not otherwise classified" or "unlisted" procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service.	New as of June, 2005
D21	New	This (these) diagnosis(es) is (are) missing or are invalid.	New as of June, 2005
23	Modified	Payment Adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments.	Modified June, 2005
47	Retired	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.	Inactive as of February, 2006
30	Retired	Payment adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.	Inactive as of February, 2006
B6	Retired	This payment is adjusted when performed/billed by this type of provider, by this type of provider in this type of facility, or by a provider of this specialty.	Inactive as of February, 2006