Medicare Learning Network
MLN Matters®
CMS
Information for Medicare Fee-For-Service Health Care Professionals

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

Note: This article was updated on October 26, 2012, to reflect current Web addresses. All other information remains unchanged.

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, including changes made from July 1, 2005, through October 30, 2005, of X12N 835 Remittance Advice Remark Codes and X12N 835 Claim Adjustment Reason Codes have been posted. The most current and complete code list will be found at http://www.wpc-edi.com/codes on the CMS website.


CAUTION – What You Need to Know

Please refer to the *Additional Information* section of this article for remark and reason code changes approved between July 1, 2005, to October 30, 2005, and in September, 2005, respectively. By April 3, 2006, all applicable code text changes and new codes should be in use and the deactivated codes terminated.

GO – What You Need to Do

The above codes are updated three times a year. Be sure your staff is aware of these changes in order to ensure correct interpretation of the electronic or paper remittance advice notices sent by Medicare.

Background

Two code sets—the claim adjustment reason code set and the remittance advice remark code set—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 (RARC) list is maintained by the Centers for Medicare & Medicaid Services (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 on the CMS website.

The RARC database has expanded rapidly in the last couple of years. CMS has developed a new website to help navigate the database more easily. A tool is provided to help search if you are looking for a specific category of code. You can also find at this site some other information that is available from the WPC website. The new website address is: http://www.cmsremarkcodes.info/ on the CMS website.

Note: This website is not replacing the WPC website as the official site where the most current RARC list resides. If there is any discrepancy, always use the list posted at the WPC website.

Additional Information

The following list summarizes changes made from July 1, 2005, through October 30, 2005:

Code	New, Modified, Deactivated, Retired	Current Narrative	Comment
Remittance Advice Remark Code Changes			
N357	New	Time frame requirements between this service procedure/ supply and a related service procedure/supply have not been met.	Medicare Initiated
N358	New	This decision may be reviewed if additional documentation as described in the contract or plan benefit documents is submitted.	Not Medicare Initiated
N359	New	Missing/incomplete/invalid height.	Not Medicare

Code	New, Modified, Deactivated, Retired	Current Narrative	Comment
			Initiated
N360	New	Coordination of benefits has not been calculated when estimating benefits for this pre-determination. Submit payment information from the primary payer with the secondary claim.	Not Medicare Initiated
N361	New	Charges are adjusted based on multiple diagnostic imaging procedure rules.	Not Medicare Initiated
N362	New	The number of Days or Units of Service exceeds our acceptable maximum.	Not Medicare Initiated
N363	New	Alert: in the near future we are implementing new policies/procedures that would affect this determination.	Not Medicare Initiated
N364	New	According to our agreement, you must waive the deductible and/or coinsurance amounts.	Medicare Initiated
M16	Modified	Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision.	Modified effective 11/18/05
MA02	Modified	If you do not agree with this determination, you have the right to appeal. You must file a written request for an appeal within 180 days of the date you receive this notice. Decisions made by a Quality Improvement Organization (QIO) must be appealed to that QIO within 60 days.	Modified effective 12/29/05 ([1])
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.	Modified effective 11/18/05 ([2])
N9	Modified	Adjustment represents the estimated amount a previous payer may pay.	Modified effective 11/18/05
N34	Modified	Incorrect claim form/format for this service.	Modified effective 11/18/05
N207	Modified	Missing/incomplete/invalid weight.	Modified effective 11/18/05
N355	Modified	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 appeal of this	Modified effective 11/18/05

Code	New, Modified, Deactivated, Retired	Current Narrative	Comment
		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 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.	
M78	Deactivated	Missing/incomplete/invalid HCPCS modifier.	Deactivated effective 5/18/06, consider using reason code 4.
Claim Adjustment Reason Code Changes			
190	New	Payment is included in the allowance for a Skilled Nursing Facility (SNF) qualified stay.	New as of 10/05
191	New	Claim denied because this is not a work related injury/illness and thus not the liability of the workers' compensation carrier.	New as of 10/05
192([3])	New	Non standard adjustment code from paper remittance advice.	New as of 10/05
182	Modified	Payment adjusted because the procedure modifier was invalid on the date of service.	Modified 8/8/05
B18	Modified	Payment adjusted because this procedure code and modifier were invalid on the date of service.	Modified 8/8/05
52	Retired	The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.	Inactive as of 2/1/06
B17	Retired	Payment adjusted because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current.	Inactive as of 2/1/06

[1] This modification is effective January 1, 2006, and has been communicated in a separate instruction (CR 4326).

[2] Medicare will not use MA03 effective from January 1, 2006, and that has been communicated in CR4326.

[3] This new code was created at the request of Medicare because:

- Providers who do not qualify for Administrative Simplification Compliance Act (ASCA) exemption must submit claims electronically;
- If Medicare is secondary, and the primary payer has sent a paper RA with proprietary code(s), the provider could not send a compliant electronic claim unless a crosswalk between the payer proprietary codes and the standard CARC is available.

In CR4123, Medicare contractors were instructed to complete entry of 192 as a valid code, and accept claims containing this code for adjudication. CMS encourages providers to utilize this code, and submit COB claims electronically.

Reason Codes 1 and 2

In September, CMS requested two new codes to be used in lieu of current reason codes 1 ("Deductible") and 2 ("Coinsurance Amount") when a provider is not allowed to collect any deductible and/or any coinsurance.

Section 630 of the Medicare Modernization Act (MMA) permits Indian Health Service (IHS) facilities to directly bill Medicare for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). Federal government agencies do not permit providers to collect coinsurance or deductible payments from IHS patients.

The committee did not approve the CMS request for new codes, but suggested that reason codes 1 and 2 should be used with Group Code CO (Contractual Obligation) instead of PR (Patient Responsibility). Currently, in most situations Group Code PR is used with reason codes 1 and 2. Medicare contractors must use Group code CO under this special situation with codes 1 and 2. (See related CR3845 and the MLN Matters article at http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM3845.pdf on the CMS website.)

The official instructions (CR4314) issued to your Medicare carrier, intermediary, DMERC, or RHHI regarding this change can be found at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R859CP.pdf on the CMS website.

If you have questions, please contact your Medicare carrier/intermediary/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.