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Information for Medicare Fee-For-Service Health Care Professionals

News Flash - Understanding the Remittance Advice: *A Guide for Medicare Providers, Physicians, Suppliers, and Billers* serves as a resource on how to read and understand a Remittance Advice (RA). Inside the guide, you will find useful information on topics such as the types of RAs, the purpose of the RA, and the types of codes that appear on the RA. To order your copy today, go to the Medicare Learning Network Product Ordering page at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/index.html on the CMS website.

MLN Matters Number: MM5721 | Related Change Request (CR) #: 5721

Related CR Release Date: September 28, 2007 | Effective Date: October 1, 2007

Related CR Transmittal #: R1345CP | Implementation Date: October 1, 2007

Note: This article was updated on September 20, 2012, to reflect current Web addresses. All other information remains the same.

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

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 DME Medicare Administrative Contractors (DME MACs)) for services

Provider Action Needed

CR 5721, from which this article is taken, announces the latest update of X12N 835 Health Care RARCs and X12N 835 and 837 Health Care CARCs, effective October 1, 2007. Be sure billing staff are aware of these changes.

Background

For transaction 835 (Health Care Claim Payment/Advice) and standard paper remittance advice, there are two code sets – Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) – that must be used to

report payment adjustments, appeal rights, and related information. Additionally, for transaction 837 coordination-of-benefits (COB), CARC must be used. These code sets are updated on a regular basis. Medicare contractors must use only currently valid codes, and make the necessary changes on a regular basis as per this recurring code update CR or the specific CR that describes the change in policy that resulted in the code change.

The RARC list is maintained by the Centers for Medicare & Medicaid Service (CMS), and used by all payers. Additions, deactivations, and modifications to the list may be initiated by both Medicare and non-Medicare entities. The health care claim adjustment reason code 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.

As mentioned earlier in CR 5634, at least one remark code must be used with the following 5 CARCs:

16 - Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

17 - Payment adjusted because requested information was not provided or was insufficient/incomplete. At least one Remark Code must be provided. (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

96 - Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

125 - Payment adjusted due to a submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

A1 - Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

Both code lists are updated three times a year, and are posted at http://wpc-edi.com/codes on the Internet. Please note that in order to synchronize with the CARC update schedule, the RARC list will be updated in early November, March and July instead of the current schedule of early December, April and August. The lists at the end of this article summarize the latest changes to these lists, as announced in CR 5721, to be effective on and after October 1, 2007 for Medicare.

CMS has also developed a new tool to help you search for a specific category of code and that tool is at http://www.cmsremarkcodes.info/ on the CMS website.

Note that this website does not replace the WPC site and, should there be any discrepancies between this site and the WPC site, consider the WPC site to be correct.

Additional Information

You can see the official instruction issued to you're A/B MAC, FI, carrier, DME MAC, or RHHI regarding these latest RARC and claim adjustment reason code updates by going to CR 5721, located at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1345CP.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.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf on the CMS website.

If you have any questions, please contact your Medicare contractor 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

New Remark Codes

Code	Current Narrative	Medicare Initiated
N380	The original claim has been processed, submit a corrected claim.	No
N381	Consult our contractual agreement for restrictions/billing/payment information related to these charges.	No
N382	Missing/incomplete/invalid patient identifier.	No
N383	Services deemed cosmetic are not covered	No
N384	Records indicate that the referenced body part/tooth has been removed in a previous procedure.	No
N385	Payment has been adjusted because notification of admission was not timely according to published plan procedures.	No

Code	Current Narrative	Medicare Initiated
N386	This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx on the CMS website. If you do not have web access, you may contact the contractor to request a copy of the NCD.	Yes
N387	You should submit this claim to the patient's other insurer for potential payment of supplemental benefits. We did not forward the claim information.	Yes

Modified Remark Codes

The following codes have been identified as "Informational" codes, and modified to add the word "Alert" in front of the current text.

M4	MA15	N59	N155	N353
M6	MA18	N84	N156	N355
M9	MA19	N85	N162	N358
M17	MA26	N88	N177	N360
M27	MA28	N89	N183	N363
M32	MA44	N130	N185	N364
M39	MA45	N132	N187	N367
M70	MA59	N133	N189	
M118	MA62	N134	N196	
MA01	MA68	N136	N202	
MA07	MA72	N137	N210	
MA08*	MA77	N138	N211	
MA10	N1	N139	N215	
MA13	N21	N140	N220	
MA14	N23	N154	N352	

*Code MA08 text has been modified further as follows:

Old Text for MA08	New Text for MA08
You should also submit this claim to the patient's other insurer for potential payment of supplemental benefits. We did not forward the claim information as the supplemental coverage is not with a Medigap plan, or you do not participate in Medicare.	Alert: Claim information was not forwarded because the supplemental coverage is not with a Medigap plan, or you do not participate in Medicare.

NOTES: Some remark codes may only provide general information that may not necessarily supplement the specific explanation provided through a reason code and in some cases another/other remark code(s) for an adjustment. Codes that are "Informational" will have "Alert" in the text to identify them as informational rather than explanatory codes. These informational codes should be used only if specific information about adjudication (like appeal rights) needs to be communicated. An example of an informational code:

N369 Alert: Although this claim has been processed, it is deficient according to state legislation/regulation.

The above information is sent per state regulation but does not explain any adjustment. These informational codes should be used only if specific information about adjudication (like appeal rights) needs to be communicated but not as default codes.

Deactivated Remark Codes

Code	Current Narrative	Notes
N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.	Deactivated effective 10/1/07. Consider using Reason Code 45
N361	Payment adjusted based on multiple diagnostic imaging procedure rules	Deactivated effective 10/1/07. Consider using Reason Code 59

X12 N Health Care Claim Adjustment Reason Code Changes

Explanation of Start, Last Modified, and Stop

- Start - Every code has a start date. This is the date when the code was first available in the code list.
- Last Modified - When populated, this is the date of the code list release when the definition of the specific code was last modified by the committee. This

date represents a point when the definition changed from one wording to another.

- Stop - When populated, this date identifies that the code can no longer be used in original business messages after that date. The code can only be used in derivative business messages (messages where the code is being reported from the original business message). For example, a CARC with a stop date of 02/01/2007 would not be able to be used by a health plan in a CAS segment in a claim payment/remittance advice transaction (835) dated after 02/01/2007 as part of an original claim adjudication. The code would still be able to be used after 02/01/2007 in derivative transactions, as long as the original usage was prior to 02/01/2007. Derivative transactions include: secondary or tertiary claims (837) from the provider or health plan to a secondary or tertiary health plan, an 835 from the original health plan to the provider as a reversal of the original adjudication. The deactivated code is usable in these derivative transactions because they are reporting on the valid usage (pre-deactivation) of the code in a previously generated 835 transaction.

New Reason Codes

Code	Current Narrative	Notes
202	Payment adjusted due to non-covered personal comfort or convenience services.	Start: 02/28/2007
203	Payment adjusted for discontinued or reduced service.	Start: 02/28/2007
204	This service/equipment/drug is not covered under the patient's current benefit plan	Start: 02/28/2007
205	Pharmacy discount card processing fee	Start: 07/09/2007
206	NPI denial - missing	Start: 07/09/2007
207	NPI denial - Invalid format	Start: 07/09/2007 Stop: 05/23/2008
208	NPI denial - not matched	Start: 07/09/2007
209	Per regulatory or other agreement, the provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to patient if collected. (Use Group code OA)	Start: 07/09/2007

Code	Current Narrative	Notes
210	Payment adjusted because pre-certification/authorization not received in a timely fashion	Start: 07/09/2007
211	National Drug Codes (NDC) not eligible for rebate, are not covered.	Start: 07/09/2007

Modified Reason Codes

Code	Current Narrative	Notes
59	Charges are adjusted based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.)	Start: 01/01/1995 Last Modified: 02/28/2007
197	Payment adjusted for absence of recertification/authorization. This change effective 1/1/2008: Payment adjusted for absence of precertification/authorization/notification.	Start: 10/31/2006 Last Modified: 07/09/2007
115	Payment adjusted as procedure postponed or canceled. This change effective 1/1/2008: Payment adjusted as procedure postponed, canceled, or delayed.	Start: 01/01/1995 Last Modified: 07/09/2007
85	Interest amount. This change effective 1/1/2008: Patient Interest Adjustment (Use Only Group code PR) Notes: only use when the payment of interest is the responsibility of the patient	Start: 01/01/1995 Last Modified: 07/09/2007

Deactivated Reason Codes

Code	Current Narrative	Notes
A2	Contractual adjustment. *Notes: Use Code 45 with Group Code 'CO' or use another appropriate specific adjustment code. The "Stop" date of 1/1/2008 may change.*	Start: 01/01/1995 Stop: 01/01/2008 Last Modified: 02/28/2007
207	NPI denial - Invalid format	Start: 07/09/2007 Stop: 05/23/2008

In addition, CR5721 contains a comprehensive list of deactivated reason codes. These codes have been deactivated prior to publication of CR5721 and have been included in previous CRs. Because of a policy change, the deactivation date may have moved from a specific version to a specific date. Contractors will not use any of these codes in any original business messages, but these codes may be used in derivative business messages (messages where the code is being reported from the original business message). This list can be viewed by accessing CR5721 at the Web address cited in the “Additional Information” section (above) of this article.