



The Medicare Appeals Process: Five Levels to Protect Providers, Physicians and Other Suppliers brochure has been updated and is now available to order print copies or as a downloadable PDF file. To view the PDF file, go to <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedicareAppealsProcess.pdf> or to order hard copies, please visit the MLN Product Ordering Page at http://cms.meridianksi.com/kc/pfs/pfs_inkfrm_fl.asp?lgnfrm=regprod&function=pfs on the CMS website.

MLN Matters Number: MM5942

Related Change Request (CR) #: 5942

Related CR Release Date: March 7, 2008

Effective Date: April 1, 2008

Related CR Transmittal #: R1475CP

Implementation Date: April 7, 2008

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

Note: This article was updated on July 12, 2013, to reflect current Web addresses. This article was previously revised on June 23, 2010, to remove a reference and link to a Web site that is no longer available. All other information is the same.

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), durable medical equipment Medicare Administrative Contractors (DME MACs)) for services

Provider Action Needed

CR 5942, from which this article is taken, announces the latest update of Remittance Advice Remark Codes (RARCs) and Claim Adjustment Reason Codes (CARCs), effective April 1, 2008. Be sure billing staff are aware of these changes.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

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 (COB) transactions. The RARC list is maintained by the Centers for Medicare & Medicaid Services (CMS), and used by all payers; and additions, deactivations, and modifications to it may be initiated by any health care organization. The CARC 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.

Both code lists are updated three times a year, and are posted at <http://www.wpc-edi.com/Codes> on the Internet. The lists at the end of this article summarize the latest changes to these lists, as announced in CR 5942-

Additional Information

To see the official instruction (CR5942) issued to your Medicare Carrier, RHHI, DME/MAC, FI and/or A/B MAC refer to <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1475CP.pdf> on the CMS website.

If you have questions, please contact your Medicare Carrier, RHHI, DME/MAC, FI and/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.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

Remittance Advice Remark Code Changes**New Codes**

Code	Current Narrative	Medicare Initiated
N430	Procedure code is inconsistent with the units billed. Start: 11/5/2007 <i>Note: (New Code 11/5/07)</i>	YES
N431	Service is not covered with this procedure. Start: 11/5/2007 <i>Note: (New Code 11/5/07)</i>	YES
N432	Adjustment based on a Recovery Audit. Start: 11/5/2007 <i>Note: (New Code 11/5/07)</i>	YES

Modified Codes

Code		
M25	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 a 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.	11/5/2007

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

Code	Current Modified Narrative	Last Modification Date
M26	<p>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.</p> <p>The requirements for refund are in 1824(l) 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.</p>	11/5/2007
M75	Multiple automated multichannel tests performed on the same day combined for payment.	11/5/2007
M112	Reimbursement for this item is based on the single payment amount required under the DMEPOS Competitive Bidding Program for the area where the patient resides.	11/5/2007
M113	Our records indicate that this patient began using this item/service prior to the current contract period for the DMEPOS Competitive Bidding Program.	11/5/2007
M114	This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or a Demonstration Project. For more information regarding these projects, contact your local contractor.	11/5/2007
M115	This item is denied when provided to this patient by a non-contract or non-demonstration supplier.	11/5/2007
N70	Consolidated billing and payment applies.	11/5/2007

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

Code	Current Modified Narrative	Last Modification Date
N367	Alert: The claim information has been forwarded to a Consumer Account Fund processor for review.	11/5/2007
N377	Payment based on a processed replacement claim.	11/5/2007
N385	Notification of admission was not timely according to published plan procedures.	11/5/2007

Deactivated Codes

Code	Current Narrative	Modification Date
MA119	Provider level adjustment for late claim filing applies to this claim. Start: 1/1/1997 Stop: 5/1/2008 Last Modified: 11/5/2007 <i>Note: (Deactivated eff. 5/1/08) Consider using Reason Code B4.)</i>	Deactivated eff. 5/1/08

Claim Adjustment Reason Codes

New Codes

Code	Current Narrative	Implementation Date
212	Administrative surcharges are not covered Start: 11/05/2007	11/05/2007

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

Modified Codes

Code	Modified Narrative	Implementation Date
121	Indemnification adjustment - compensation for outstanding member responsibility. Start: 01/01/1995 Last Modified: 09/30/2007	4/1/2008
192	Non standard adjustment code from paper remittance. Note: This code is to be used by providers/payers providing Coordination of Benefits information to another payer in the 837 transaction only. This code is only used when the non-standard code cannot be reasonably mapped to an existing Claims Adjustment Reason Code, specifically Deductible, Coinsurance and Co-payment. Start: 10/31/2005 Last Modified: 09/30/2007	4/1/2008
206	National Provider Identifier - missing. Start: 07/09/2007 Last Modified: 09/30/2007	4/1/2008
207	National Provider identifier - Invalid format Start: 07/09/2007 Stop: 05/23/2008 Last Modified: 09/30/2007	4/1/2008
208	National Provider Identifier - Not matched. Start: 07/09/2007 Last Modified: 09/30/2007	4/1/2008
15	The authorization number is missing, invalid, or does not apply to the billed services or provider. Start: 01/01/1995 Last Modified: 09/30/2007	4/1/2008
17	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.) Start: 01/01/1995 Last Modified: 09/30/2007	4/1/2008
19	This is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier. Start: 01/01/1995 Last Modified: 09/30/2007	4/1/2008

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

Code	Modified Narrative	Implementation Date
20	This injury/illness is covered by the liability carrier. Start: 01/01/1995 Last Modified: 09/30/2007	4/1/2008
21	This injury/illness is the liability of the no-fault carrier. Start: 01/01/1995 Last Modified: 09/30/2007	4/1/2008
22	This care may be covered by another payer per coordination of benefits. Start: 01/01/1995 Last Modified: 09/30/2007	4/1/2008
23	The impact of prior payer(s) adjudication including payments and/or adjustments. Start: 01/01/1995 Last Modified: 09/30/2007	4/1/2008
24	Charges are covered under a capitation agreement/managed care plan. Start: 01/01/1995 Last Modified: 09/30/2007	4/1/2008
31	Patient cannot be identified as our insured. Start: 01/01/1995 Last Modified: 09/30/2007	4/1/2008
33	Insured has no dependent coverage. Start: 01/01/1995 Last Modified: 09/30/2007	4/1/2008
34	Insured has no coverage for newborns. Start: 01/01/1995 Last Modified: 09/30/2007	4/1/2008
55	Procedure/treatment is deemed experimental/investigational by the payer. Start: 01/01/1995 Last Modified: 09/30/2007	4/1/2008
56	Procedure/treatment has not been deemed 'proven to be effective' by the payer. Start: 01/01/1995 Last Modified: 09/30/2007	4/1/2008
58	Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Start: 01/01/1995 Last Modified: 09/30/2007	4/1/2008
59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or	4/1/2008

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

Code	Modified Narrative	Implementation Date
	diagnostic imaging, concurrent anesthesia.) Start: 01/01/1995 Last Modified: 09/30/2007	
61	Penalty for failure to obtain second surgical opinion. Start: 01/01/1995 Last Modified: 09/30/2007	4/1/2008
95	Plan procedures not followed. Start: 01/01/1995 Last Modified: 09/30/2007	4/1/2008
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Start: 01/01/1995 Last Modified: 09/30/2007	4/1/2008
107	The related or qualifying claim/service was not identified on this claim. Start: 01/01/1995 Last Modified: 09/30/2007	4/1/2008
108	Rent/purchase guidelines were not met. Start: 01/01/1995 Last Modified: 09/30/2007	4/1/2008
112	Service not furnished directly to the patient and/or not documented. Start: 01/01/1995 Last Modified: 09/30/2007	4/1/2008
115	Procedure postponed, canceled, or delayed. Start: 01/01/1995 Last Modified: 09/30/2007	4/1/2008
116	The advance indemnification notice signed by the patient did not comply with requirements. Start: 01/01/1995 Last Modified: 09/30/2007	4/1/2008
117	Transportation is only covered to the closest facility that can provide the necessary care. Start: 01/01/1995 Last Modified: 09/30/2007	4/1/2008
118	ESRD network support adjustment. Start: 01/01/1995 Last Modified: 09/30/2007	4/1/2008
125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP	4/1/2008

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

Code	Modified Narrative	Implementation Date
	Reject Reason Code.) Start: 01/01/1995 Last Modified: 09/30/2007	
129	Prior processing information appears incorrect. Start: 02/28/1997 Last Modified: 09/30/2007	4/1/2008
135	Interim bills cannot be processed. Start: 10/31/1998 Last Modified: 09/30/2007	4/1/2008
136	Failure to follow prior payer's coverage rules. (Use Group Code OA). Start: 10/31/1998 Last Modified: 09/30/2007	4/1/2008
137	Regulatory Surcharges, Assessments, Allowances or Health Related Taxes. Start: 02/28/1999 Last Modified: 09/30/2007	4/1/2008
138	Appeal procedures not followed or time limits not met. Start: 06/30/1999 Last Modified: 09/30/2007	4/1/2008
141	Claim spans eligible and ineligible periods of coverage. Start: 06/30/1999 Last Modified: 09/30/2007	4/1/2008
142	Monthly Medicaid patient liability amount. Start: 06/30/2000 Last Modified: 09/30/2007	4/1/2008
146	Diagnosis was invalid for the date(s) of service reported. Start: 06/30/2002 Last Modified: 09/30/2007	4/1/2008
148	Information from another provider was not provided or was insufficient/incomplete. Start: 06/30/2002 Last Modified: 09/30/2007	4/1/2008
150	Payer deems the information submitted does not support this level of service. Start: 10/31/2002 Last Modified: 09/30/2007	4/1/2008

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

Code	Modified Narrative	Implementation Date
151	Payer deems the information submitted does not support this many services. Start: 10/31/2002 Last Modified: 09/30/2007	4/1/2008
152	Payer deems the information submitted does not support this length of service. Start: 10/31/2002 Last Modified: 09/30/2007	4/1/2008
153	Payer deems the information submitted does not support this dosage. Start: 10/31/2002 Last Modified: 09/30/2007	4/1/2008
154	Payer deems the information submitted does not support this day's supply. Start: 10/31/2002 Last Modified: 09/30/2007	4/1/2008
155	Patient refused the service/procedure. Start: 06/30/2003 Last Modified: 09/30/2007	4/1/2008
157	Service/procedure was provided as a result of an act of war. Start: 09/30/2003 Last Modified: 09/30/2007	4/1/2008
158	Service/procedure was provided outside of the United States. Start: 09/30/2003 Last Modified: 09/30/2007	4/1/2008
159	Service/procedure was provided as a result of terrorism. Start: 09/30/2003 Last Modified: 09/30/2007	4/1/2008
160	Injury/illness was the result of an activity that is a benefit exclusion. Start: 09/30/2003 Last Modified: 09/30/2007	4/1/2008
163	Attachment referenced on the claim was not received. Start: 06/30/2004 Last Modified: 09/30/2007	4/1/2008
164	Attachment referenced on the claim was not received in a timely fashion.	4/1/2008

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

Code	Modified Narrative	Implementation Date
	Start: 06/30/2004 Last Modified: 09/30/2007	
165	Referral absent or exceeded. Start: 10/31/2004 Last Modified: 09/30/2007	4/1/2008
168	Service(s) have been considered under the patient's medical plan. Benefits are not available under this dental plan. Start: 06/30/2005 Last Modified: 09/30/2007	4/1/2008
169	Alternate benefit has been provided. Start: 06/30/2005 Last Modified: 09/30/2007	4/1/2008
173	Service was not prescribed by a physician. Start: 06/30/2005 Last Modified: 09/30/2007	4/1/2008
174	Service was not prescribed prior to delivery. Start: 06/30/2005 Last Modified: 09/30/2007	4/1/2008
175	Prescription is incomplete. Start: 06/30/2005 Last Modified: 09/30/2007	4/1/2008
176	Prescription is not current. Start: 06/30/2005 Last Modified: 09/30/2007	4/1/2008
177	Patient has not met the required eligibility requirements. Start: 06/30/2005 Last Modified: 09/30/2007	4/1/2008
178	Patient has not met the required spend down requirements. Start: 06/30/2005 Last Modified: 09/30/2007	4/1/2008
179	Patient has not met the required waiting requirements. Start: 06/30/2005 Last Modified: 09/30/2007	4/1/2008
180	Patient has not met the required residency requirements. Start: 06/30/2005 Last Modified: 09/30/2007	4/1/2008

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

Code	Modified Narrative	Implementation Date
181	Procedure code was invalid on the date of service. Start: 06/30/2005 Last Modified: 09/30/2007	4/1/2008
182	Procedure modifier was invalid on the date of service. Start: 06/30/2005 Last Modified: 09/30/2007	4/1/2008
186	Level of care change adjustment. Start: 06/30/2005 Last Modified: 09/30/2007	4/1/2008
191	Not a work related injury/illness and thus not the liability of the workers' compensation carrier. Start: 10/31/2005 Last Modified: 09/30/2007	4/1/2008
194	Anesthesia performed by the operating physician, the assistant surgeon or the attending physician. Start: 02/28/2006 Last Modified: 09/30/2007	4/1/2008
195	Refund issued to an erroneous priority payer for this claim/service. Start: 02/28/2006 Last Modified: 09/30/2007	4/1/2008
197	Precertification/authorization/notification absent. Start: 10/31/2006 Last Modified: 09/30/2007	4/1/2008
198	Precertification/authorization exceeded. Start: 10/31/2006 Last Modified: 09/30/2007	4/1/2008
202	Precertification/authorization exceeded. Start: 10/31/2006 Last Modified: 09/30/2007	4/1/2008
203	Discontinued or reduced service. Start: 02/28/2007 Last Modified: 09/30/2007	4/1/2008
A8	Ungroupable DRG. Start: 01/01/1995 Last Modified: 09/30/2007	4/1/2008
B5	Coverage/program guidelines were not met or were exceeded. Start: 01/01/1995 Last Modified: 09/30/2007	4/1/2008

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

Code	Modified Narrative	Implementation Date
B8	Alternative services were available, and should have been utilized. Start: 01/01/1995 Last Modified: 09/30/2007	4/1/2008
B9	Patient is enrolled in a Hospice. Start: 01/01/1995 Last Modified: 09/30/2007	4/1/2008
B14	Only one visit or consultation per physician per day is covered. Start: 01/01/1995 Last Modified: 09/30/2007	4/1/2008
B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Start: 01/01/1995 Last Modified: 09/30/2007	4/1/2008
B16	'New Patient' qualifications were not met. Start: 01/01/1995 Last Modified: 09/30/2007	4/1/2008
B18	This procedure code and modifier were invalid on the date of service. Start: 01/01/1995 Last Modified: 09/30/2007	4/1/2008
B20	Procedure/service was partially or fully furnished by another provider. Start: 01/01/1995 Last Modified: 09/30/2007	4/1/2008
B23	Procedure billed is not authorized per your Clinical Laboratory Improvement Amendment (CLIA) proficiency test. Start: 01/01/1995 Last Modified: 09/30/2007	4/1/2008

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

Deactivated Codes

Code	Current Narrative	Implementation Date
25	Payment denied. Your Stop loss deductible has not been met. Start: 01/01/1995 Stop: 04/01/2008	4/1/2008
126	Deductible -- Major Medical Start: 02/28/1997 Stop: 04/01/2008 Last Modified: 09/30/2007 Notes: Use Group Code PR and code 1.	4/1/2008
127	Coinsurance -- Major Medical Start: 02/28/1997 Stop: 04/01/2008 Last Modified: 09/30/2007 Notes: Use Group Code PR and code 2.	4/1/2008
145	Premium payment withholding Start: 06/30/2002 Stop: 04/01/2008 Last Modified: 09/30/2007 Notes: Use Group Code CO and code 45.	4/1/2008
A4	Medicare Claim PPS Capital Day Outlier Amount. Start: 01/01/1995 Stop: 04/01/2008 Last Modified: 09/30/2007	4/1/2008

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.