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

MLN Matters Number: MM6109 Revised **Related Change Request (CR) #: 6109**

Related CR Release Date: July 25, 2008 **Effective Date: October 1, 2008**

Related CR Transmittal #: R1563CP **Implementation Date: October 6, 2008**

Remittance Advice Remark Code and Claim Adjustment Reason Code Update

Note: This article was revised on January 17, 2018, to update Web addresses. All other information remains 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), and Durable Medical Equipment Medicare Administrative Contractors (DME MACs)) for services.

Impact on Providers

CR 6109, from which this article is taken, announces the latest update of Remittance Advice Remark Codes (RARC) used in electronic and paper remittance advice, and Claim Adjustment Reason Codes (CARC) used in electronic and paper remittance advice and coordination of benefits (COB) claim transactions. These changes will be effective October 1, 2008. Be sure that your billing staffs are 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 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 on the Washington Publishing Company (WPC) website at ***http://www.wpc-edi.com/Codes*** on the Internet. The tables at the end of this article (right after the "Additional Information" section) summarize the latest changes to these lists, as announced in CR6109.

Additional Information

To see the official instruction (CR 6109) 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/R1563CP.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. The changes that are effective on October 1, 2008 are as follows:

Remittance Advice Remark Code changes

New Codes

Code	Current Narrative	Medicare Initiated
N433	Resubmit this claim using only your National Provider Identifier (NPI)	Y

Modified Codes

Code	Current Modified Narrative	Last Modified
MA97	Missing/incomplete/invalid Medicare Managed Care Demonstration contract number or clinical trial registry number.	2/29/08
N175	Missing review organization approval.	2/29/08
N241	Incomplete/invalid review organization approval.	2/29/08
N421	Claim payment was the result of a payer's retroactive adjustment due to a review organization decision.	2/29/08

Deactivated Codes - None

Health Care Claim Adjustment Reason Codes

New Codes

Code	Current Narrative	Effective Date (per WPC website)
213	Non-compliance with the physician self referral prohibition legislation or payer policy.	1/27/2008
214	Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment. (Note: To be used for Workers' Compensation only)	1/27/2008
215	Based on subrogation of a third party settlement	1/27/2008
216	Based on the findings of a review organization	1/27/2008
217	Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement. (Note: To be used for Workers' Compensation only)	1/27/2008
218	Based on entitlement to benefits (Note: To be used for Workers' Compensation only)	1/27/2008
219	Based on extent of injury (Note: To be used for Workers' Compensation only)	1/27/2008
220	The applicable fee schedule does not contain the billed code. Please resubmit a bill with the appropriate fee schedule code(s) that best describe the service(s) provided and supporting documentation if required. (Note: To be used for Workers' Compensation only)	1/27/2008
221	Workers' Compensation claim is under investigation. (Note: To be used for Workers' Compensation only. Claim pending final resolution)	1/27/2008
D22	Reimbursement was adjusted for the reasons to be provided in separate correspondence. (Note: To be used for Workers' Compensation only) - Temporary code to be added for timeframe only until 01/01/2009. Another code to be established and/or for 06/2008 meeting for a revised code to replace or strategy to use another existing code	1/27/2008

Modified Codes

Code	Modified Narrative	Effective Date (per WPC website.
151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.	1/27/2008

Deactivated Codes

Code	Current Narrative	Effective Date (per WPC website)
D22	Reimbursement was adjusted for the reasons to be provided in separate correspondence. (Note: To be used for Workers' Compensation only) - Temporary code to be added for timeframe only until 01/01/2009. Another code to be established and/or for 06/2008 meeting for a revised code to replace or strategy to use another existing code	1/1/2009

Document History

- August 3, 2008 – Initial article released.
- January 17, 2018 – The article is revised to update Web addresses. All other information remains the same.