DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

News Flash – Has Medicare sent you a notice to revalidate your enrollment? If you are not sure, you can find lists of providers sent notices to revalidate their Medicare enrollment by scrolling to the "Downloads" section at http://www.CMS.gov/MedicareProviderSupEnroll/11_Revalidations.asp on the Centers for Medicare & Medicaid Services (CMS) website. That site currently contains links to lists of providers sent notices from September, 2011 through January, 2012. Information on revalidation letters sent in February will be posted in late March. For ease of reference, the lists are in order by National Provider Identifier and the date the notice was sent.

MLN Matters® Number: MM7775

Related Change Request (CR) #: CR 7775

Related CR Release Date: April 6, 2012

Effective Date: July 1, 2012

Related CR Transmittal #: R2442CP

Implementation Date: July 2, 2012

Claim Adjustment Reason Code (CARC), Remittance Advice Remark Code (RARC), Medicare Remit Easy Print (MREP), and PC Print Update

Provider Types Affected

This MLN Matters® Article is intended for physicians, providers, suppliers, and vendors representing physicians/providers/suppliers receiving remittance advice from Medicare contractors (carriers, Durable Medical Equipment Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), A/B Medicare Administrative Contractors (A/B MACs), and/or Regional Home Health Intermediaries (RHHIs)) for services provided to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You

This article is based on Change Request (CR) 7775 which updates Claim Adjustment Reason Codes (CARCs), Remittance Advice Remark Codes (RARCs), Medicare Remit Easy Print (MREP), and PC Print for Medicare.

CAUTION – What You Need to Know

Change Request (CR) 7775 instructs Medicare contractors and the Shared System Maintainers (SSMs) to make programming changes to incorporate new, modified, and deactivated CARCs and RARCs that have been added since the last recurring code update CR (CR 7683 Transmittal 2372 published on December 22, 2011). It also instructs Fiscal Intermediary Standard System (FISS) and VIPs Medicare System (VMS) to update PC Print and Medicare Remit Easy Print (MREP) software respectively. Be sure your billing staff is aware of these changes.

GO – What You Need to Do

If you use the MREP or PC Print software, be sure to download the updated software when available. See the Background and Additional Information Sections of this article for further details regarding these changes.

Background

The Health Insurance Portability and Accountability Act (HIPAA) of 1996, instructs health plans to be able to conduct standard electronic transactions adopted under HIPAA using valid standard codes. Medicare policy states that Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) that provide either supplemental explanation for a monetary adjustment or policy information that generally applies to the monetary adjustment are required in the remittance advice and coordination of benefits transactions. . For transaction 835 (Health Care Claim Payment/Advice) and standard paper remittance advice, valid CARCs and RARCs must be used to report payment adjustments, appeal rights, and related information. If there is any adjustment, the appropriate Group Code must be reported as well.

The CARC and RARC changes that impact Medicare are usually requested by the Centers for Medicare & Medicaid Services (CMS) staff in conjunction with a policy change. Medicare contractors and Shared System Maintainers (SSMs) are notified about these changes in the corresponding instructions from the specific CMS component that implements the policy change, in addition to the regular code update notification. If a modification has been initiated by an entity other than CMS for a code currently used by Medicare, then Medicare contractors must either use the modified code or another code if the modification makes the modified code inappropriate to explain the specific reason for adjustment for Medicare.

Medicare contractors will stop using codes that have been deactivated on or before the effective date specified in the comment section (as posted on the Washington Publishing Company (WPC) website). In order to comply with any deactivation, Medicare may have to stop using the deactivated code in original business messages **before** the actual "Stop Date" posted on the WPC website because the code list is updated three times a year and may not align with the Medicare release schedule. Note that a deactivated code used in derivative messages must be accepted even after the code is

deactivated if the deactivated code was used before the deactivation date by a payer who adjudicated the claim before Medicare. Medicare contractors must stop using any deactivated reason and/or remark code past the deactivation date whether the deactivation is requested by Medicare or any other entity.

The regular code update CR will establish the implementation date for all modifications, deactivations, and any new code for Medicare contractors and the SSMs. If another specific CR has been issued by another CMS component with a different implementation date, the earlier of the two dates will apply for Medicare implementation. If any new or modified code has an effective date past the implementation date specified in CR7775, Medicare contractors must implement on the date specified on the WPC website.

The discrepancy between the dates may arise because the WPC website is updated only 3 times a year and may not match the CMS release schedule.

CR7775 lists only the changes that have been approved since the last code update CR (CR 7683 Transmittal 2372), and does not provide a complete list of codes in these two code sets. You must get the complete list for both CARC and RARC from the WPC website that is updated three times a year – around March 1, July 1, and November 1 – to get the comprehensive lists for both code sets, but the implementation date for any new or modified or deactivated code for Medicare contractors is established by this recurring code update CR published three or four times a year according to the Medicare release schedule.

The WPC website (at http://www.wpc-edi.com/Reference on the Internet) has four listings available for both CARC and RARC:

1. All: All codes including deactivated and to be deactivated codes are included in this listing.
2. To Be Deactivated: Only codes to be deactivated at a future date are included in this listing.
3. Deactivated: Only codes with prior deactivation effective date are included in this listing.
4. Current: Only currently valid codes are included in this listing.

Note: In case of any discrepancy in the code text as posted on WPC website and as reported in any CR, the WPC version is implemented by Medicare.

Claim Adjustment Reason Code (CARC):

A national code maintenance committee maintains the health care Claim Adjustment Reason Codes (CARCs). The Committee meets at the beginning of each X12 trimester meeting (January/February, June and September/October) and makes decisions about additions, modifications, and retirement of existing reason codes. The updated list is posted three times a year around early March, July, and November. To access the updated list see http://www.wpc-edi.com/Reference on the Internet

The new codes usually become effective when approved unless mentioned otherwise. Any modification or deactivation becomes effective on a future date to provide lead time for implementing necessary programming changes. Exception: The effective date for a modification may be as early as

the approval or publication date if the requester can provide enough justification to have the modification become effective earlier.. A health plan may decide to implement a code deactivation before the actual effective date posted on WPC website as long as the deactivated code is allowed to come in on Coordination of Benefits (COB) claims if the previous payer(s) has (have) used that code prior to the deactivation date. In most cases Medicare will stop using a deactivated code before the deactivation becomes effective per the WPC website to accommodate the Medicare release schedule.

The following new Claim Adjustment Reason Codes were approved by the Code Committee in January, and must be implemented, if appropriate for Medicare, by July 2, 2012.

New Codes – CARC:

None

Modified Codes – CARC:

Code	Modified Narrative	Effective Date
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	11/1/2012
239	Claim spans eligible and ineligible periods of coverage. Rebill separate claims.	11/1/2012

Deactivated Codes – CARC:

None

Remittance Advice Remark Codes (RARC):

CMS is the national maintainer of the remittance advice remark code list. This code list is used by reference in the ASC X12 N transaction 835 (Health Care Claim Payment/Advice) version 004010A1 and 005010A1 Implementation Guide (IG)/Technical Report (TR) 3. Under HIPAA, all payers, including Medicare, have to use reason and remark codes approved by X12 recognized code set maintainers instead of proprietary codes to explain any adjustment in the claim payment. CMS as the X12 recognized maintainer of RARCs receives requests from Medicare and non- Medicare entities for new codes and modification/deactivation of existing codes. Additions, deletions, and modifications to the code list resulting from non-Medicare requests may or may not impact Medicare. Remark and reason code changes that impact Medicare are usually requested by CMS staff in conjunction with a policy change. Medicare uses the standard code sets (CARC and RARC) for paper remittance advice as well.

New Codes – RARC:

Code	Code Narrative	Effective Date
N547	A refund request (Frequency Type Code 8) was processed previously.	3/6/2012

Code	Code Narrative	Effective Date
N548	Alert: Patient's calendar year deductible has been met.	3/6/2012
N549	Alert: Patient's calendar year out-of-pocket maximum has been met.	3/6/2012
N550	Alert: You have not responded to requests to revalidate your provider/supplier enrollment information. Your failure to revalidate your enrollment information will result in a payment hold in the near future.	3/6/2012
N551	Payment adjusted based on the Ambulatory Surgical Center (ASC) Quality Reporting Program.	3/6/2012
N552	Payment adjusted to reverse a previous withhold/bonus amount.	3/6/2012
N553	Payment adjusted based on a Low Income Subsidy (LIS) retroactive coverage or status change.	3/6/2012

Modified Codes – RARC:

Code	Modified Narrative	Effective Date
N4	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.	3/6/2012
N206	The supporting documentation does not match the information sent on the claim.	3/6/2012

Deactivated Codes – RARC:

None

Additional Information

The official instruction, CR7775, issued to your carriers, DME MACs, FIs, A/B MACs, and RHHIs regarding this change may be viewed at http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2442CP.pdf release on the CMS website.

If you have any questions, please contact your carriers, DME MACs, FIs, A/B MACs, or RHHIs at their toll-free number, which may be found at http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS website.