DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

News Flash – The 2013 ICD-10-PCS files have been posted on the 2013 ICD-10 PCS and GEMs web page. This includes the 2013 Index and Tabular files, guidelines, code titles, addendum to reference manual, and slides. The 2013 ICD-10-PCS files contain information on the new procedure coding system, ICD-10-PCS, that is being developed as a replacement for ICD-9-CM, Volume 3. The "2013 General Equivalent Mappings (GEMs), Reimbursement Mappings, and Reference Manual" will be posted at a later date.

MLN Matters® Number: MM8029

Related Change Request (CR) #: CR 8029

Related CR Release Date: August 17, 2012

Effective Date: October 1, 2012

Related CR Transmittal #: R2521CP

Implementation Date: October 1, 2012

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

Provider Types Affected

This MLN Matters® Article is intended for physicians, other providers, and suppliers who submit claims to 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

This article is based on Change Request (CR) 8029 which instructs Medicare contractors and Shared System Maintainers (SSMs) to make programming changes to incorporate new, modified, and deactivated Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) that have been added since the last recurring code update. It also instructs Fiscal Intermediary Standard System (FISS) and VIPs Medicare System (VMS) maintainers to update PC Print and Medicare Remit Easy Print (MREP) software. Make sure that your billing staffs are aware of these changes.

Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA; see http://www.gpo.gov/fdsys/pkg/PLAW-104publ191/pdf/PLAW-104publ191.pdf on the Internet), instructs health plans to be able to conduct standard electronic transactions adopted under HIPAA using valid standard codes. Medicare policy states that CARCs and appropriate RARCs that provide either supplemental explanation for a monetary adjustment or global policy information that generally applies to the adjudication process are required in remittance advice (RA) and coordination of benefits (COB) transactions. For transaction 835 (Health Care Claim Payment/Advice) and standard paper remittance advice (RA), there are two code sets – CARC and RARC – that 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. Additionally, CARC and RARC must be used for transaction 837 COB.

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. 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.

Medicare contractors 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 or payers 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 CR 8029, Medicare contractors must implement on the date specified on the WPC website.

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

CR 8029 lists only the changes that have been approved since the last code update provided by CR 7775 (Transmittal 2442 issued on April 6, 2012; see http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2442CP.pdf on the CMS website).

CR 8029 does not provide a complete list of CARCs and RARCs, and the MACs and the SSMs must get the complete list for both CARCs and RARCs from the WPC website which is updated three times a year (around March 1, July 1, and November 1).

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 (see http://www.wpc-edi.com/Reference) has four listings available of Codes by Status for both CARC and RARC.

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

NOTE 1: In case of any discrepancy in the code text as posted on the WPC website and as reported in any CR, the WPC version should be implemented.

NOTE 2: CR8029 lists only the changes approved since the last recurring Code Update CR once. If any change becomes effective at a future date, Medicare contractors must make sure that they update on the quarterly release date that matches the effective date as posted on the WPC website. If the effective date per the WPC website does not match any quarterly release date, Medicare contractors may update earlier than the effective date per WPC website for any deactivation, and later than the effective date per WPC website for any modification or new code.

CARCs

A national code maintenance committee maintains the health care CARCs, and a new code may not be added and the indicated wording may not be modified without the approval of this committee. These codes were developed for use by all U.S. health payers. As a result, they are generic, and there are a number of codes that do not apply to Medicare.

This code set is updated three times a year, and the updated list is published three times a year after the committee meets before the ANSI ASC X12 trimester meeting in the months of January/February, June, and September/October.

The full list of CARCs can be found and downloaded from http://wpc-edi.com/Reference and to find out more about CARCs, see the "Medicare Claims Processing Manual" (Chapter 22, Sections 60.1 and 130.2 at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c22.pdf on the CMS website.

New CARCs were approved by the Code Committee, and the following changes were made in the CARC database since the last code update provided by CR 7775. These changes must be implemented, if appropriate for Medicare, by October 1, 2012.

New CARCs

Code	Code Narrative	Effective Date
240	The diagnosis is inconsistent with the patient's birth weight. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	6/3/2012
241	Low Income Subsidy (LIS) Co-payment Amount.	6/3/2012
242	Services not provided by network/primary care providers.	6/3/2012
243	Services not authorized by network/primary care providers.	6/3/2012

Modified CARCs

Code	Code Narrative	Effective date
133	The disposition of the claim/service is pending further review. This change effective 1/1/2013: The disposition of the claim/service is pending further review. Use Group Code OA..	6/3/2012

Deactivated CARCs

Code	Code Narrative	Effective Date
38	Services not provided or authorized by designated (network/primary care) providers.	1/1/2013

Remittance Advice Remark Codes (RARCs)

Remittance Advice Remark Codes (RARCs) are maintained by CMS and may be used by any health plan when they apply. Medicare contractors must report appropriate remark code(s) that apply in both electronic and paper remittance advice, and COB claims. RARCs are used in a remittance advice to further explain an adjustment in conjunction with an appropriate CARC or relay general information about the adjudication process. .

The remark code list is updated three times a year, and the list as posted at the WPC website and gets updated at the same time when the reason code list is updated. Both code lists are updated on or around March 1, July 1, and November 1. Medicare contractors must use the currently valid remark codes as included in the Recurring Update Notification and/or any other CMS instruction. Medicare contractors also must get the full list of RARCs by downloading the list from the WPC website after each update. Contractor and shared system changes must be made, as necessary, as part of a routine release to reflect changes such as retirement of previously used codes or introduction of newly created codes that may impact Medicare.

The list of Remittance Advice Remark Codes (RARCs) can be found at http://www.wpc-edi.com/codes on the Internet.

For more information about Remark Codes

You can find out more about CARCs in the "Medicare Claims Processing Manual" (Publication 100-04, Chapter 22, Section 60.2, and 130.3 at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c22.pdf on the CMS website.

These following changes were made in the RARC database since the last code update provided by CR 7775. The full RARC list must be downloaded from the WPC website at http://wpc-edi.com/Reference on the Internet.

New RARCs

Code	Code Narrative	Effective Date
N554	Missing/Incomplete/Invalid Family Planning Indicator	7/1/2012
N555	Missing medication list.	7/1/2012
N556	Incomplete/invalid medication list.	7/1/2012
N557	This claim/service is not payable under our service area. The claim must be filed to the Payer/Plan in whose service area the specimen was collected.	7/1/2012
N558	This claim/service is not payable under our service area. The claim must be filed to the Payer/Plan in whose service area the equipment was received.	7/1/2012
N559	This claim/service is not payable under our service area. The claim must be filed to the Payer/Plan in whose service area the Ordering Physician is located.	7/1/2012

Modified RARCs

Code	Modified Code Narrative	Effective Date
N69	PPS (Prospective Payment System) code changed by claims processing system.	7/1/2012
N103	Social Security records indicate that this patient was a prisoner when the service was rendered. This payer does not cover items	7/1/2012

Code	Modified Code Narrative	Effective Date
	and services furnished to an individual while he or she is in a Federal facility, or while he or she is in State or local custody under a penal authority, unless under State or local law, the individual is personally liable for the cost of his or her health care while incarcerated and the State or local government pursues such debt in the same way and with the same vigor as any other debt.	

Deactivated RARCs

None

Medicare contractors must report only currently valid codes in both the RA and COB Claim transactions, and must allow deactivated CARC and RARC in derivative messages when certain conditions are met (see the Business Requirements segment of CR8029 for explanation of conditions). SSMs and Medicare contractors must make the necessary changes on a regular basis as per this recurring code update CR and/or the specific CR that describes the change in policy that resulted in the code change requested by Medicare. Any modification and/or deactivation will be implemented by Medicare even when the modification and/or the deactivation has not been initiated by Medicare.

Additional Information

The official instruction, CR8029, issued to your contractor regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2521CP.pdf on the CMS website.

If you have any questions, please contact your 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.