DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

News Flash –

REVISED products from the Medicare Learning Network® (MLN)

"Basic Medicare Information for Providers and Suppliers," Guide, ICN 005933, Downloadable only.

MLN Matters® Number: MM8154

Related Change Request (CR) #: CR 8154

Related CR Release Date: December 21, 2012

Effective Date: April 1, 2013

Related CR Transmittal #: R2618CP

Implementation Date: April 1, 2013

Remittance Advice Remark and Claims Adjustment Reason Code, Medicare Remit Easy Print, and PC Print Update

Provider Types Affected

This MLN Matters® Article is intended for physicians, other providers, and suppliers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), carriers, Regional Home Health Intermediaries (RHHIs), Durable Medical Equipment Medicare Administrative Contractors (DME/MACs) and A/B Medicare Administrative Contractors (A/B MACs) for services to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 8154 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 Medicare System maintainers to update PC Print and Medicare Remit Easy Print (MREP) software. Make sure that your billing staffs are aware of these changes. See the Background and Additional Information Sections of this article for further details regarding 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. 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 CR8154, 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 schedule for releasing its system updates.

CR8154 lists only the changes that have been approved since the last code update CR (CR 8029, Transmittal 2521, issued on August 17, 2012), and does not provide a complete list of codes for these two code sets.

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

The CARC and RARC changes reflected by CR8154 are as follows:

New Codes – CARC:

Code	Code Narrative	Effective Date
244	Payment reduced to zero due to litigation. Additional information will be sent following the conclusion of litigation. To be used for Property & Casualty only.	9/30/2012
245	Provider performance program withhold.	9/30/2012
246	This non-payable code is for required reporting only.	9/30/2012
247	Deductible for Professional service rendered in an Institutional setting and billed on an Institutional claim. *Notes: For Medicare Bundled Payment use only, under the Patient Protection and Affordable Care Act (PPACA).*	9/30/2012
248	Coinsurance for Professional service rendered in an Institutional setting and billed on an Institutional claim. *Notes: For Medicare Bundled Payment use only, under the Patient Protection and Affordable Care Act (PPACA).*	9/30/2012
249	This claim has been identified as a resubmission. (Use only with Group Code CO)	9/30/2012
250	The attachment content received is inconsistent with the expected content.	9/30/2012

Code	Code Narrative	Effective Date
251	The attachment content received did not contain the content required to process this claim or service	9/30/2012
252	An attachment is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	9/30/2012
W3	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. For use by Property and Casualty only.	9/30/2012
W4	Workers' Compensation Medical Treatment Guideline Adjustment.	9/30/2012
Y1	Payment denied based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional regulations or payment policies, use only if no other code is applicable. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for P&C Auto only. Start: 09/30/2012	9/30/2012
Y2	Payment adjusted based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional regulations or payment policies, use only if no other code is applicable. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for P&C Auto only. Start: 09/30/2012	9/30/2012

Code	Code Narrative	Effective Date
Y3	Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for P&C Auto only.	9/30/2012

Modified Codes – CARC:

Code	Modified Narrative	Effective Date
18	Duplicate claim/service. This change effective 1/1/2013: Exact duplicate claim/service (Use only with Group Code OA)	1/1/2013
23	The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA)	9/30/2012
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability). This change effective 7/1/2013: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability)	9/30/2012
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 only with Group Code OA)	9/30/2012
136	Failure to follow prior payer's coverage rules. (Use Group Code OA). This change effective 7/1/2013: Failure to follow prior payer's coverage rules. (Use only with Group Code OA)	7/1/2013
173	Service was not prescribed by a physician. This change effective 7/1/2013: Service/equipment was not prescribed by a physician.	7/1/2013
201	Workers' Compensation case settled. Patient is responsible for amount of this claim/service through WC 'Medicare set aside arrangement' or other agreement. (Use group code PR). This change effective 7/1/2013: Workers Compensation case settled. Patient is responsible for amount of this claim/service through WC 'Medicare set aside arrangement' or other agreement. (Use only with Group Code PR)	7/1/2013

Code	Modified Narrative	Effective Date
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) This change effective 7/1/2013: 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 only with Group code OA)	7/1/2013
217	Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement. (Note: To be used for Property and Casualty only)	9/30/2012
220	The applicable fee schedule/fee database does not contain the billed code. Please resubmit a bill with the appropriate fee schedule/fee database code(s) that best describe the service(s) provided and supporting documentation if required. (Note: To be used for Property and Casualty only)	9/30/2012
221	Workers' Compensation claim is under investigation. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). This change effective 7/1/2013: Claim is under investigation. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). (Note: To be used by Property & Casualty only)	9/30/2012
226	Information requested from the Billing/Rendering Provider was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) This change effective 7/1/2013: Information requested from the Billing/Rendering Provider was not provided or not provided timely or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	7/1/2013

Code	Modified Narrative	Effective Date
229	Partial charge amount not considered by Medicare due to the initial claim Type of Bill being 12X. Note: This code can only be used in the 837 transaction to convey Coordination of Benefits information when the secondary payer's cost avoidance policy allows providers to bypass claim submission to a prior payer. Use Group Code PR. This change effective 7/1/2013: Partial charge amount not considered by Medicare due to the initial claim Type of Bill being 12X. Note: This code can only be used in the 837 transaction to convey Coordination of Benefits information when the secondary payer's cost avoidance policy allows providers to bypass claim submission to a prior payer. (Use only with Group Code PR)	7/1/2013
236	This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative. This change effective 7/1/2013: This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/ fee	7/1/2013
238	Claim spans eligible and ineligible periods of coverage, this is the reduction for the ineligible period (use Group Code PR). This change effective 7/1/2013: Claim spans eligible and ineligible periods of coverage, this is the reduction for the ineligible period. (Use only with Group Code PR)	7/1/2013

Deactivated Codes – CARC: None

New Codes – RARC:

Code	Code Narrative	Effective Date
N560	The pilot program requires an interim or final claim within 60 days of the Notice of Admission. A claim was not received.	11/1/2012
N561	The bundled claim originally submitted for this episode of care includes related readmissions. You may resubmit the original claim to receive a corrected payment based on this readmission.	11/1/2012
N562	The provider number of your incoming claim does not match the provider number on the processed Notice of Admission (NOA) for this bundled payment.	11/1/2012

Code	Code Narrative	Effective Date
N563	Missing required provider/supplier issuance of advance patient notice of non-coverage. The patient is not liable for payment for this service.	11/1/2012
N564	Patient did not meet the inclusion criteria for the demonstration project or pilot program.	11/1/2012
N565	Alert: This procedure code requires a modifier. Future claims containing this procedure code must include an appropriate modifier for the claim to be processed.	11/1/2012
N566	Alert: This procedure code requires functional reporting. Future claims containing this procedure code must include an applicable non-payable code and appropriate modifiers for the claim to be processed.	11/1/2012

Modified Codes – RARC:

Code	Modified Narrative	Effective Date
M39	The Note: (Modified 2/1/04, 4/1/07, 11/1/09) Related to N563	11/1/2012
M137	Part B coinsurance under a demonstration project or pilot program.	11/1/2012

Deactivated Codes – RARC:

Code	Narrative	Effective Date
N553	Payment adjusted based on a Low Income Subsidy (LIS) retroactive coverage or status change.	11/1/2012

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 CR8154 for an 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, CR8154 issued to your FI, carrier, RHHI, DME/MAC, and A/B MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2618CP.pdf on the CMS website. For more information on CARC and RARC codes go to http://www.wpc-edi.com/Reference on the internet.

If you have any questions, please contact your FI, carrier, RHHI, DME/MAC, 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.

News Flash - Flu Season is Here- According to the Centers for Disease Control and Prevention, flu activity is beginning to increase and further increases are expected in the coming weeks and months. Now is the time to protect against flu before activity increases in the community. About 5 to 20 percent of the population gets the flu each year and more than 200,000 people are hospitalized because of flu-related complications. Make each office visit an opportunity to talk with your patients about the importance of getting an annual flu vaccination and a pneumococcal vaccination according to the recommended schedule. This message also serves as a reminder for you to get your seasonal flu vaccination to protect yourself, your family, and your patients.

Remember – the Influenza and pneumococcal vaccines and their administration fees are covered Part B benefits. Influenza and pneumococcal vaccines are NOT Part D-covered drugs.

CMS has posted the 2012-2013 Seasonal Influenza Vaccines Pricing list. You may also refer to the MLN Matters® Article #MM8047, "Influenza Vaccine Payment Allowances - Annual Update for 2012-2013 Season."

Please visit the CMS Medicare Learning Network® Preventive Services Educational Products and CMS Immunizations web pages for more information on coverage and billing of the flu and pneumococcal vaccines and their administration fees.

While some providers may offer the flu vaccine, those who don't can help their patients locate a vaccine provider within their local community. The HealthMap Vaccine Finder is a free, online service where users can find nearby locations offering flu vaccines.