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

Flu Shot Reminder

It's Not Too Late to Get the Flu Shot. We are in the midst of flu season and a flu vaccine is still the best way to prevent infection and the complications associated with the flu. But re-vaccination is necessary each year because the flu viruses change each year. Encourage your Medicare patients who haven't already done so to get their annual flu shot and don't forget to immunize yourself and your staff. Protect yourself, your patients, and your family and friends. Get Your Flu Shot. It's Not Too Late! Remember - Influenza vaccination is a covered Part B benefit. Note that influenza vaccine is NOT a Part D covered drug. For more information about Medicare's coverage of adult immunizations and educational resources, go to CMS's website: http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/SE0667.pdf.

MLN Matters Number: MM5456 Revised
Related Change Request (CR) #: 5456
Related CR Release Date: January 26, 2007
Effective Date: April 1, 2007
Related CR Transmittal #: R1163CP
Implementation Date: April 2, 2007

Note: This article was updated on August 27, 2012,, to reflect current Web addresses. All other information is the same.

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

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 regional carriers (DMERCs) and DME Medicare Administrative Contractors (DME MACs)) for services.

Provider Action Needed

CR 5456, from which this article is taken, announces the latest update of X12N 835 Health Care Remittance Advice Remark Codes and X12N 835 and 837 Health Care Claim Adjustment Reason Codes, effective April 2, 2007. Be sure billing staff 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 some coordination-of-benefits (COB) transactions. The RARC list is maintained by the Centers for Medicare & Medicaid Service (CMS), and used by all payers; and additions, deactivations, and modifications to it may be initiated by both Medicare and non-Medicare entities. The health care claim adjustment reason code 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://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 5456, effective on and after April 1, 2007.

CMS has also developed a new tool to help you search for a specific category of code and that tool is at http://www.cmsremarkcodes.info on the CMS website. Note that this website does not replace the WPC site and, should there be any discrepancies between this site and the WPC site, consider the WPC site to be correct.

Additional Information

You can see the official instruction issued to your FI/carrier/DMERC/RHHI regarding these latest RARC and claim adjustment reason code updates by going to CR 5456, located at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1163CP.pdf on the CMS website.

For additional information about Remittance Advice, please refer to *Understanding the Remittance Advice (RA): A Guide for Medicare Providers, Physicians, Suppliers, and Billers at* http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf *on the* CMS website.

If you have any questions, please contact your Medicare 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.

X12N 835 Remittance Advice Remark Code Changes

New Codes

Code	Current Narrative	Medicare Initiated
N373	It has been determined that another payer paid the services as primary when they were not the primary payer. Therefore, we are refunding to the payer that paid as primary on your behalf. Note: (New Code 12/1/06)	No
N374	Primary Medicare Part A insurance has been exhausted and a Part B Remittance Advice is required. Note: (New Code 12/1/06)	No
N375	Missing/incomplete/invalid questionnaire/information required to determine dependent eligibility. Note: (New Code 12/1/06)	No
N376	Subscriber/patient is assigned to active military duty, therefore primary coverage may be TRICARE. *Note: (New Code 12/1/06)*	No
N377	Payment adjusted based on a processed replacement claim. Note: (New Code 12/1/06)	No
N378	Missing/incomplete/invalid prescription quantity. Note: (New Code 12/1/06)	No
N379	Claim level information does not match line level information. Note: (New Code 12/1/06)	No

Modified Codes

Code	Current Narrative	Modification Date
M143	The provider must update license information with the payer. Note: (Modified 12/1/06)	12/01/06
N181	Additional information is required from another provider involved in this service. Note: (New Code 2/28/03. Modified 12/1/06)	12/01/06
N361	Payment adjusted based on multiple diagnostic imaging procedure rules Note: (New Code 11/18/05. Modified 12/1/06)	12/01/06
There are NO deactivated codes		

NOTE II: Some remark codes may provide information that may not necessarily supplement the explanation provided through a reason code and in some cases another/other remark code(s) for an adjustment. Newly created informational codes will have "Alert" in the text to identify them as informational rather than explanatory codes. An example of an informational code:

N369 Alert: Although this claim has been processed, it is deficient according to state legislation/regulation.

The above information is sent per state regulation, but does not explain any adjustment. These informational codes should be used only if specific information needs to be communicated but not as default codes.

X12 N 835 Health Care Claim Adjustment Reason Codes

New Codes

Code	Current Narrative	Notes
197	Payment denied/reduced for absence of precertification/authorization Note: New as of 10/06	New as of 10/06
198	Payment denied/reduced for exceeded, precertification/authorization Note: New as of 10/06	New as of 10/06
199	Revenue code and Procedure code do not match. Note: New as of 10/06	New as of 10/06
200	Expenses incurred during lapse in coverage Note: New as of 10/06	New as of 10/06
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). Note: New as of 10/06	New as of 10/06

Modified Codes

Code	Current Narrative	Notes
42	Charges exceed our fee schedule or maximum allowable amount. Note: Changed as of 10/06. This code will be deactivated on 6/1/2007.	Modified as of 10/06 Effective 6/1/2007
45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability). Note: Changed as of 10/06	Modified as of 10/06 Effective 6/1/2007 Note: This code replaces code 42 (above) on June 1, 2007.

Code	Current Narrative	Notes
62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization. Note: Changed as of 2/01 and 10/06. This code will be deactivated on 4/1/2007.	Modified as of 10/06
97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated Note: Changed as of 2/99 and 10/06.	Modified as of 10/06
107	Claim/service adjusted because the related or qualifying claim/service was not identified on this claim. *Note: Changed as of 6/03 and 10/06.*	Modified as of 10/06
136	Claim adjusted based on failure to follow prior payer's coverage rules. (Use Group Code OA). Note: Changed as of 6/00 and 10/06.	Modified as of 10/06
196	Claim/service denied based on prior payer's coverage determination. Note: New as of 6/06. Changed 10/06. This code will be deactivated on 2/1/2007, beginning on that date, value 136 will be used.	Modified as of 10/06
A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code). Note: Changed as of 10/06	Modified as of 10/06
B15	Payment adjusted because this service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Changed as of 2/01 and 10/06.	Modified as of 10/06
D17	Claim/Service has invalid non-covered days. *Note: This code will be deactivated on 2/1/2007 and code 16 will then be used with appropriate claim payment remark code [M32, M33].*	Modified as of 10/06
D18	Claim/Service has missing diagnosis information. Note: This code will be deactivated on 2/1/2007 and then code 16 will be used with appropriate claim payment remark code [MA63, MA65].	Modified as of 10/06
D19	Claim/Service lacks Physician/Operative or other supporting documentation Note: This code will be deactivated on 2/1/2007 and code 16 will be used with appropriate claim payment remark code [M29, M30, M35, M66].	Modified as of 10/06
D20	Claim/Service missing service/product information. Note: This code will be deactivated on 2/1/2007 and code 16 will be used with appropriate claim payment remark code [M20, M67, M19, MA67].	Modified as of 10/06

Code	Current Narrative	Notes
D21	This (these) diagnosis(es) is (are) missing or are invalid Note: New as of 6/05. This code will be deactivated on 2/1/2007.	Modified as of 10/06