DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

News Flash –

New product from the Medicare Learning Network® (MLN)

- "Medicare Fraud & Abuse: Prevention, Detection, and Reporting," Fact Sheet, ICN 0006827, downloadable

MLN Matters® Number: MM7683 Revised

Related CR Release Date: December 22. 2011

Related CR Transmittal #: R3372CP

Related Change Request (CR) #: CR 7683

Effective Date: April 1, 2012

Implementation Date: April 2, 2012

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

Note: This article was updated on July 31, 2012, to reflect current Web addresses. All other information remains the same.

Provider Types Affected

Physicians, providers, and suppliers submitting 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

STOP – Impact to You

This article is based on Change Request (CR) 7683 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) 7683 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. It also instructs Fiscal Intermediary Standard System (FISS) and VIPs Medicare System (VMS) to update PC Print and Medicare Remit Easy Print (MREP) software. Be sure your billing staff is aware of these changes.

GO – What You Need to Do

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) are required in the remittance advice and coordination of benefits transactions. Medicare policy further states that appropriate 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 transaction. For transaction 835 (Health Care Claim Payment/Advice) and standard paper remittance advice, CARCs and RARCs must be used to report payment adjustments, appeal rights, and related information. If there is any adjustment, appropriate Group Code must be reported as well. Additionally, for transaction 837 COB, CARC must be used.

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.

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) if they are currently being used. 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 Change Request (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 CR7683, 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.

CR7683 lists only the changes that have been approved since the last code update CR (CR 7514 Transmittal 2304), 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 (see above for exception).

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 than a future date. 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 October, and must be implemented, if appropriate, by April 2, 2012.

New Codes – CARC:

Code	Current Narrative	Effective Date
238	Claim spans eligible and ineligible periods of coverage, this is the reduction for the ineligible period (use Group Code PR).	3/1/2012
239	Claim spans eligible and ineligible periods of coverage. Rebill separate claims (use Group Code OA).	3/1/2012

Modified Codes – CARC:

Code	Modified Narrative	Effective Date
18	Exact duplicate claim/service (Use with Group Code OA).	1/1/2013

Deactivated Codes – CARC:

Code	Current Narrative	Effective Date
141	Claim spans eligible and ineligible periods of coverage.	7/1/2012

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.

CR7683 contains no new, modified, or deactivated RARC codes.

Additional Information

The official instruction, CR7683, issued to your carriers, DME MACs, FIs, A/B MACs, and RHHIs regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2372CP.pdf 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/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.

News Flash - It's a Busy Time of Year. Make each office visit an opportunity to remind your patients about the importance of getting the seasonal flu vaccination and a one-time pneumococcal vaccination. Medicare pays for these vaccinations for all beneficiaries with no co-pay or deductible. The Centers for Disease Control and Prevention also recommends that healthcare workers and caregivers be vaccinated against the seasonal flu. Protect your patients. Protect your family. Protect yourself. Get the Flu Vaccine – Not the Flu. Remember: The flu vaccine plus its administration are covered Part B benefits. The flu vaccine is NOT a Part D-covered drug. For more information on coverage and billing of the flu vaccine and its administration, and related educational provider resources, visit the following CMS web pages Medicare Learning Network® Preventive Services and Immunizations. Get the Flu Vaccine -- Not the Flu. For the 2011-2012 seasonal flu vaccine payment limits, visit http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/index.html.