Program Memorandum Intermediaries/Carriers

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal AB-03-095 **Date: JULY 3, 2003**

CHANGE REQUEST 2788

SUBJECT: Remittance Advice Remark and Reason Code Update

I. GENERAL INFORMATION

This Program Memorandum (PM) updates remark and reason codes for intermediaries, carriers and Durable Medical Equipment Regional Contractors (DMERCs).

A. Background: X12N 835 Health Care Remittance Advice Remark Codes

CMS is the national maintainer of the remittance advice remark code list that is one of the code lists mentioned in ASC X12 transaction 835 (Health Care Claim Payment/Advice) version 4010A1 Implementation Guide (IG). Under the Health Insurance Portability and Accountability Act (HIPAA), all payers, including Medicare, have to use reason and remark codes approved by X12 recognized maintainers instead of proprietary codes to explain any adjustment in the payment. CMS receives a significant number of requests for new remark codes and modifications in existing remark codes from non-Medicare entities, and these additions and modifications may not impact Medicare. Traditionally, remark code changes that impact Medicare are requested by Medicare staff in conjunction with a policy change. Contractors are notified of those new/modified codes in the corresponding implementation instructions in the form of a PM or manual instruction implementing the policy change, in addition to the regular code update PM. The code changes initiated by Medicare have been identified in this PM to single out codes that must be implemented by the contractors and the Shared System maintainers. In the current database 5 new codes are duplicative, and will be deactivated in the next update. These duplicate codes are shown in this PM in italics, and do not need to be implemented. Use codes N157, N158, N159, N160, N161 in lieu of N164, N165, N166, N168, and N169. If a modification has been initiated by an entity other than Medicare for a code currently used by Medicare, contractors must use the modified code even though the modification was not initiated by Medicare. If a new code is not initiated by Medicare, contractors do not have to use it unless otherwise instructed by Medicare. Contractors must stop using codes that have been retired on or before the date in the comment section if they are currently being used.

The list of remark codes is available at http://www.cms.hhs.gov/providers/edi/hipaadoc.asp and http://www.wpc-edi.com/hipaa/, and the list is updated 3 times a year – in the months following X12 trimester meetings. By October 1, 2003, you must have completed entry of all applicable code changes and new codes for use in production to make sure that you are using the latest approved remark codes as included in any CMS instructions in your 835 version 4010A1 and subsequent versions, the corresponding standard paper remittance advice transactions, and any other ANSI X12 transaction where these codes may be used (e.g., 837 COB). 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 newly created codes that may impact Medicare.

The following list summarizes changes made through February 28, 2003.

New Remark Codes

Code	Current Narrative	Medicare Initiated
N157	Transportation to and from this destination is not covered.	**YES**
N158	Transportation in a vehicle other than an ambulance is not covered.	**YES**
N159	Payment denied/reduced because mileage is not covered when the patient is not in the ambulance.	**YES**
N160	The beneficiary/patient must choose an option before this procedure/equipment/supply/service can be covered.	**YES**
N161	This drug/service/supply is covered only when the associated service is covered.	**YES**
N162	This is an alert. Although your claim was paid, you have billed for a test/specialty not included in your Laboratory Certification. Your failure to correct the laboratory certification information will result in a denial of payment in the near future.	**YES**
N163	Medical record does not support code billed per the code definition.	**YES**
N164	*Transportation to/from this destination is not covered.*	*YES*
N165	*Transportation in a vehicle other than an ambulance is not covered.*	*YES*
N166	*Payment denied/reduced because mileage is not covered when the patient is not in the ambulance.*	*YES*
N167	Charges exceed the post-transplant coverage limit.	**YES**
N168	*The beneficiary must choose an option before a payment can be made for this procedure/equipment/supply/service.*	*YES*
N169	*This drug/service/supply is covered only when the associated service is covered.*	*YES*
N170	A new/revised/renewed certificate of medical necessity is needed.	**YES**
N171	Payment for repair or replacement is not covered or has exceeded the purchase price.	**YES**
172	The patient is not liable for the denied/adjusted charge(s) for receiving any updated service/item.	**YES**

Code	Current Narrative	Medicare Initiated
N173	No qualifying hospital stay dates were provided for this episode of care.	**YES**
N174	This is not a covered service/procedure/ equipment/bed, however patient liability is limited to amounts shown in the adjustments under group "PR".	**YES**
N175	Missing/incomplete/invalid Review Organization Approval.	**YES**
N176	Services provided aboard a ship are covered only when the ship is of United States registry and is in United States waters. In addition, a doctor licensed to practice in the United States must provide the service.	**YES**
N177	We did not send this claim to beneficiary's other insurer. They have indicated no additional payment can be made.	**YES**
N178	Missing/invalid/incomplete pre-operative photos or visual field results.	**YES**
N179	Additional information has been requested from the member. The charges will be reconsidered upon receipt of that information.	
N180	This item or service does not meet the criteria for the category under which it was billed.	
N181	Additional information has been requested from another provider involved in the care of this member. The charges will be reconsidered upon receipt of that information.	
N182	This claim/service must be billed according to the schedule for this plan.	
N183	This is a predetermination advisory message, when this service is submitted for payment additional documentation as specified in plan documents will be required to process benefits.	
N184	Rebill technical and professional components separately.	
N185	Do not resubmit this claim/service.	
N186	Non-Availability Statement (NAS) required for this service. Contact the nearest Military Treatment Facility (MTF) for assistance.	
N187	You may request a review in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.	
N188	The approved level of care does not match the procedure code submitted.	
N189	This service has been paid as a one-time exception to the plan's benefit restrictions.	
N190	Missing/incomplete/invalid contract indicator.	
N191	The provider must update insurance information directly with payer.	
N192	Patient is a Medicaid/Qualified Medicare Beneficiary.	

Code	Current Narrative	Medicare Initiated
N193	Specific federal/state/local program may cover this service through another payer.	
N194	Technical component not paid if provider does not own the equipment used.	
N195	The technical component must be billed separately.	
N196	Patient eligible to apply for other coverage which may be primary.	
N197	The subscriber must update insurance information directly with payer.	
N198	Rendering provider must be affiliated with the pay-to provider.	
N199	Additional payment approved based on payer-initiated review/audit.	
N200	The professional component must be billed separately.	
N201	A mental health facility is responsible for payment of outside providers who furnish these services/supplies to residents.	

Modified Remark Codes

Code	Current Modified Narrative	Modification Date
M19	Missing/incomplete/invalid oxygen certification/re-certification.	(Modified 2/28/03)
M20	Missing/incomplete/invalid HCPCS.	(Modified 2/28/03)
M21	Missing/incomplete/invalid place of residence for this service/item provided in a home.	(Modified 2/28/03)
M22	Missing/incomplete/invalid number of miles traveled.	(Modified 2/28/03)
M23	Invoice needed for the cost of the material or contrast agent.	
M24	Missing/incomplete/invalid number of doses per vial.	(Modified 2/28/03)
M29	Missing/incomplete/invalid operative report.	(Modified 2/28/03)
M30	Missing/incomplete/invalid pathology report.	(Modified 2/28/03)
M31	Missing/incomplete/invalid radiology report.	(Modified 2/28/03)
M33	Missing/incomplete/invalid UPIN for the ordering/referring/performing provider.	(Modified 2/28/03)
M34	Claim lacks the CLIA certification number.	
M35	Missing/incomplete/invalid pre-operative photos or visual field results.	(Modified 2/28/03)
M44	Missing/incomplete/invalid condition code.	(Modified 2/28/03)
M45	Missing/incomplete/invalid occurrence codes or dates.	(Modified 2/28/03)
M46	Missing/incomplete/invalid occurrence span code or dates.	(Modified 2/28/03)
M47	Missing/incomplete/invalid internal or document control number.	(Modified 2/28/03)
M49	Missing/incomplete/invalid value code(s) or amount(s).	(Modified 2/28/03)
M50	Missing/incomplete/invalid revenue code(s).	(Modified 2/28/03)

Code	Current Modified Narrative	Modification Date
M51	Missing/incomplete/invalid procedure code(s) and/or rates.	(Modified 2/28/03)
M52	Missing/incomplete/invalid "from" date(s) of service.	(Modified 2/28/03)
M53	Missing/incomplete/invalid days or units of service.	(Modified 2/28/03)
M54	Missing/incomplete/invalid total charges.	(Modified 2/28/03)
M56	Missing/incomplete/invalid payer identifier.	(Modified 2/28/03)
M57	Missing/incomplete/invalid provider identifier.	(Modified 2/28/03)
M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.	(Modified 2/28/03)
M59	Missing/incomplete/invalid "to" date(s) of service.	(Modified 2/28/03)
M62	Missing/incomplete/invalid treatment authorization code.	(Modified 2/28/03)
M64	Missing/incomplete/invalid other diagnosis.	(Modified 2/28/03)
M67	Missing/incomplete/invalid other procedure code(s) and/or date(s).	(Modified 2/28/03)
M68	Missing/incomplete/invalid attending or referring physician identification.	(Modified 2/28/03)
M76	Missing/incomplete/invalid diagnosis or condition.	(Modified 2/28/03)
M77	Missing/incomplete/invalid place of service.	(Modified 2/28/03)
M78	Missing/incomplete/invalid HCPCS modifier.	(Modified 2/28/03)
M79	Missing/incomplete/invalid charge.	(Modified 2/28/03)
M81	Patient's diagnosis in a narrative form is not provided on an attachment or diagnosis code(s) is truncated, incorrect or missing; you are required to code to the highest level of specificity.	(Modified 2/28/02)
M99	Missing/incomplete/invalid Universal Product Number/Serial Number.	(Modified 2/28/03)
M108	Missing/incomplete/invalid provider identifier for the provider who interpreted the diagnostic test.	(Modified 2/28/03)
M110	Missing/incomplete/invalid provider identifier for the provider from whom you purchased interpretation services.	(Modified 2/28/03)
M119	Missing/incomplete/invalid National Drug Code (NDC).	(Modified 2/28/03)
M120	Missing/incomplete/invalid provider identifier for the substituting physician who furnished the service(s) under a reciprocal billing or locum tenens arrangement.	(Modified 2/28/03)
M122	Missing/incomplete/invalid level of subluxation.	(Modified 2/28/03)
M123	Missing/incomplete/invalid name, strength, or dosage of the drug furnished.	(Modified 2/28/03)
M124	Missing/incomplete/invalid indication of whether the patient owns the equipment that requires the part or supply.	(Modified 2/28/03)
M125	Missing/incomplete/invalid information on the period of time for which the service/supply/equipment will be needed.	(Modified 2/28/03)
M126	Missing/incomplete/invalid individual lab codes included in the test.	(Modified 2/28/03)
M127	Missing/incomplete/invalid patient medical record for this service.	(Modified 2/28/03)
M128	Missing/incomplete/invalid date of the patient's last physician visit.	(Modified 2/28/03)

Code	Current Modified Narrative	Modification Date
M129	Missing/incomplete/invalid indicator of X-ray availability for review.	(Modified 2/28/03)
M130	Missing/incomplete/invalid invoice or statement certifying the actual cost of the lens, less discounts, and/or the type of intraocular lens used.	(Modified 2/28/03)
M131	Missing/incomplete/invalid physician financial relationship form.	(Modified 2/28/03)
M132	Missing/incomplete/invalid pacemaker registration form.	(Modified 2/28/03)
M135	Missing/incomplete/invalid plan of treatment.	(Modified 2/28/03)
M136	Missing/incomplete/invalid indication that the service was supervised or evaluated by a physician.	(Modified 2/28/03)
M141	Missing/incomplete/invalid physician certified plan of care.	(Modified 2/28/03)
M142	Missing/incomplete/invalid American Diabetes Association Certificate of Recognition.	(Modified 2/28/03)
MA06	Missing/incomplete/invalid beginning and/or ending date(s).	(Modified 2/28/03)
MA27	Missing/incomplete/invalid entitlement number or name shown on the claim.	(Modified 2/28/03)
MA29	Missing/incomplete/invalid provider name, city, state, or zip code.	(Modified 2/28/03)
MA30	Missing/incomplete/invalid type of bill.	(Modified 2/28/03)
MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.	(Modified 2/28/03)
MA32	Missing/incomplete/invalid number of covered days during the billing period.	(Modified 2/28/03)
MA33	Missing/incomplete/invalid noncovered days during the billing period.	(Modified 2/28/03)
MA34	Missing/incomplete/invalid number of coinsurance days during the billing period.	(Modified 2/28/03)
MA35	Missing/incomplete/invalid number of lifetime reserve days.	(Modified 2/28/03)
MA36	Missing/incomplete/invalid patient name.	(Modified 2/28/03)
MA37	Missing/incomplete/invalid patient's address.	(Modified 2/28/03)
MA38	Missing/incomplete/invalid birth date.	(Modified 2/28/03)
MA39	Missing/incomplete/invalid gender.	(Modified 2/28/03)
MA40	Missing/incomplete/invalid admission date.	(Modified 2/28/03)
MA41	Missing/incomplete/invalid admission type.	(Modified 2/28/03)
MA42	Missing/incomplete/invalid admission source.	(Modified 2/28/03)
MA43	Missing/incomplete/invalid patient status.	(Modified 2/28/03)
MA48	Missing/incomplete/invalid name or address of responsible party or primary payer.	(Modified 2/28/03)
MA49	Missing/incomplete/invalid six-digit provider identifier for home health agency or hospice for physician(s) performing care plan oversight services.	(Modified 2/28/03)
MA50	Missing/incomplete/invalid Investigational Device Exemption number for FDA-approved clinical trial services.	(Modified 2/28/03)

Code	Current Modified Narrative	Modification Date
MA51	Missing/incomplete/invalid CLIA certification number for laboratory services billed by physician office laboratory.	(Modified 2/28/03)
MA52	Missing/incomplete/invalid date.	(Modified 2/28/03)
MA58	Missing/incomplete/invalid release of information indicator.	(Modified 2/28/03)
MA60	Missing/incomplete/invalid patient relationship to insured.	(Modified 2/28/03)
MA61	Missing/incomplete/invalid social security number or health insurance claim number.	(Modified 2/28/03)
MA63	Missing/incomplete/invalid principal diagnosis.	(Modified 2/28/03)
MA65	Missing/incomplete/invalid admitting diagnosis.	(Modified 2/28/03)
MA66	Missing/incomplete/invalid principal procedure code or date.	(Modified 2/28/03)
MA69	Missing/incomplete/invalid remarks.	(Modified 2/28/03)
MA70	Missing/incomplete/invalid provider representative signature.	(Modified 2/28/03)
MA71	Missing/incomplete/invalid provider representative signature date.	(Modified 2/28/03)
MA75	Missing/incomplete/invalid patient or authorized representative signature.	(Modified 2/28/03)
MA76	Missing/incomplete/invalid provider identifier for HHA or hospice when physician is performing care plan oversight services.	(Modified 2/28/03)
MA81	Missing/incomplete/invalid provider/supplier signature.	(Modified 2/28/03)
MA82	Missing/incomplete/invalid provider/supplier billing number/identifier or billing name, address, city, state, zip code, or phone number.	(Modified 2/28/03)
MA86	Missing/incomplete/invalid group or policy number of the insured for the primary coverage.	(Modified 2/28/03)
MA87	Missing/incomplete/invalid insured's name for the primary payer.	(Modified 2/28/03)
MA88	Missing/incomplete/invalid insured's address and/or telephone number for the primary payer.	(Modified 2/28/03)
MA89	Missing/incomplete/invalid patient's relationship to the insured for the primary payer.	(Modified 2/28/03)
MA90	Missing/incomplete/invalid employment status code for the primary insured.	(Modified 2/28/03)
MA92	Missing/incomplete/invalid primary insurance information.	(Modified 2/28/03)
MA95	De-activate and refer to M51.	(Modified 2/28/03)
MA97	Missing/incomplete/invalid Medicare Managed Care Demonstration contract number.	(Modified 2/28/03)
MA99	Missing/incomplete/invalid Medigap information.	(Modified 2/28/03)
MA100	Missing/incomplete/invalid date of current illness, injury or pregnancy.	(Modified 2/28/03)
MA102	Missing/incomplete/invalid name or provider identifier for the rendering/referring/ordering/supervising provider.	(Modified 2/28/03)
MA104	Missing/incomplete/invalid date the patient was last seen or the provider identifier of the attending physician.	(Modified 2/28/03)

Code	Current Modified Narrative	Modification Date
MA105	Missing/incomplete/invalid provider number for this place of service.	(Modified 2/28/03)
MA110	Missing/incomplete/invalid information on whether the diagnostic test(s) were performed by an outside entity or if no purchased tests are included on the claim.	(Modified 2/28/03)
MA111	Missing/incomplete/invalid purchase price of the test(s) and/or the performing laboratory's name and address.	(Modified 2/28/03)
MA112	Missing/incomplete/invalid group practice information.	(Modified 2/28/03)
MA114	Missing/incomplete/invalid information on where the services were furnished.	(Modified 2/28/03)
MA115	Missing/incomplete/invalid physical location (name and address, or PIN) where the service(s) were rendered in a Health Professional Shortage Area (HPSA).	(Modified 2/28/03)
MA120	Missing/incomplete/invalid CLIA certification number.	(Modified 2/28/03)
MA121	Missing/incomplete/invalid date the X-Ray was performed.	(Modified 2/28/03)
MA122	Missing/incomplete/invalid initial date actual treatment occurred.	(Modified 2/28/03)
MA128	Missing/incomplete/invalid six-digit FDA approved, identification number.	(Modified 2/28/03)
MA129	This provider was not certified for this procedure on this date of service.	(Modified 2/28/03)
N1	You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.	(Modified 2/28/03)
N3	Missing/incomplete/invalid consent form.	(Modified 2/28/03)
N4	Missing/incomplete/invalid prior insurance carrier EOB.	(Modified 2/28/03)
N6	Under FEHB law (U.S.C. 8904(b)), we cannot pay more for covered care than the amount Medicare would have allowed if the patient were enrolled in Medicare Part A and/or Medicare Part B.	(Modified 2/28/03)
N24	Missing/incomplete/invalid Electronic Funds Transfer (EFT) banking information.	(Modified 2/28/03)
N26	Missing/incomplete/invalid itemized bill.	(Modified 2/28/03)
N27	Missing/incomplete/invalid treatment number.	(Modified 2/28/03)
N29	Missing/incomplete/invalid documentation/orders/notes/summary/report/invoice.	(Modified 2/28/03)
N31	Missing/incomplete/invalid prescribing/referring/attending provider license number.	(Modified 2/28/03)
N37	Missing/incomplete/invalid tooth number/letter.	(Modified 2/28/03)
N38	Missing/incomplete/invalid place of service.	(Modified 2/28/03)
N40	Missing/incomplete/invalid X-Ray.	(Modified 2/28/03)
N50	Missing/incomplete/invalid discharge information.	(Modified 2/28/03)
N53	Missing/incomplete/invalid point of pick-up address.	(Modified 2/28/03)
N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	(Modified 2/28/03)

Code	Current Modified Narrative	Modification Date
N57	Missing/incomplete/invalid prescribing/dispensed date.	(Modified 2/28/03)
N58	Missing/incomplete/invalid patient liability amount.	(Modified 2/28/03)
N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	(Modified 2/28/03)
N66	Missing/incomplete/invalid documentation.	(Modified 2/28/03)
N70	Home health consolidated billing and payment applies.	(Modified 2/28/02)
N71	Your unassigned claim for a drug or biological, clinical diagnostic laboratory services or ambulance service was processed as an assigned claim. You are required by law to accept assignment for these types of claim.	(Modified 2/21/02)
N73	A Skilled Nursing Facility is responsible for payment of outside providers who furnish these services/supplies under arrangement to its residents.	(Modified 7/24/01, 2/28/03)
N75	Missing/incomplete/invalid tooth surface information.	(Modified 2/28/03)
N76	Missing/incomplete/invalid number of riders.	(Modified 2/28/03)
N77	Missing/incomplete/invalid designated provider number.	(Modified 2/28/03)
N80	Missing/incomplete/invalid prenatal screening information.	(Modified 2/28/03)
N95	This provider type/provider specialty may not bill this service.	(New code 7/31/01, Modified 2/28/03)
N103	Social Security records indicate that this beneficiary was a prisoner when the service was rendered. This payer does not cover items and services furnished to beneficiaries while they are in State or local custody under a penal authority, unless under State or local law, the beneficiary 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.	(New code 12/05/01, Modified 4/8/02, Modified 2/28/03)
N108	Missing/incomplete/invalid upgrade information.	(Modified 2/28/03)

Retired Remark Codes:

Code	Current Narrative	Comment
M72	Did not enter full 8-digit date (MM/DD/CCYY).	(M72 will no longer be valid effective 10/16/2003. Use MA52)
MA05	Incorrect admission date patient status or type of bill entry on claim.	(MA05 will no longer be valid effective 10/16/2003. Use MA30 or MA40 or MA43.)
MA98	Claim Rejected. Does not contain the correct Medicare Managed Care Demonstration contract number for this beneficiary.	(MA98 will no longer be valid effective 10/16/2003. Use MA 97)

Code	Current Narrative	Comment
N41	Authorization request denied.	(N41 will no longer be valid effective 10/16/2003. Use Claim Adjustment Reason Code 39)
N44	Payer's share of regulatory surcharges, assessments, allowances or health care-related taxes paid directly to the regulatory authority.	(N44 will no longer be valid effective 10/16/2003. Use Claim Adjustment Reason Code 137)

X12 N 835 Health Care Claim Adjustment Reason Codes

The Health Care Code Maintenance Committee maintains the health care claim adjustment reason codes. The committee did not approve any reason code change in February 2003.

B. Policy:

Contractors and the Shared System Maintainers (SSMs) must implement the necessary changes by October 1, 2003.

II. BUSINESS REQUIREMENTS

Requirement #	Requirements	Responsibility
1.1	Replace retired and modified codes that are applicable to Medicare	Intermediaries/ Carriers/ DMERCs/SSMs
1.2	Add new codes that are applicable to Medicare	Intermediaries/ Carriers/ DMERCs/SSMs
1.3	Appropriate provider education about changes in remittance advice codes. Intermediaries/Carriers/DMERCs must inform affected provider communities by posting relevant portions of this instruction on their Web sites within 2-3 weeks of the issuance date on this instruction. In addition, this same information must be published in your next regularly scheduled bulletin. If you have a listserv that targets the affected provider communities, you must use it to notify subscribers that information about Remittance Advice Remark and Reason Code Update is available on your Web site.	Intermediaries/ Carriers/ DMERCs

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions

B. Design Considerations:

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces:

D. Contractor Financial Reporting /Workload Impact:

E. Dependencies:

F. Testing Considerations:

IV. ATTACHMENT(S)

Version: Implementation Date: October 1, 2003 Discard Date: October 1, 2004 Post-Implementation Contact: Sumita Sen ssen@cms.hhs.gov or 410-786-5755	Effective Date: October 1, 2003 Funding: These instructions should be implemented within your current operating budget Pre-Implementation Contact: Sumita Sen ssen@cms.hhs.gov or 410-786-5755