CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1384	**Date: NOVEMBER 30, 2007**
	Change Request 5800

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

I. SUMMARY OF CHANGES: This Change Request instructs contractors to update the Remittance Advice Remark Codes (RARC) and Claim Adjustment Reason Codes (CARC) used in the paper and electronic remittance advice. This also instructs VIPs to update the code database to be used in conjunction with the software - Medicare Remit Easy Print (MREP).

NEW / REVISED MATERIAL
EFFECTIVE DATE: *January 1, 2008
IMPLEMENTATION DATE: January 7, 2008

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
N/A	

III. FUNDING:
SECTION A: For Fiscal Intermediaries and Carriers: No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Recurring Update Notification

**Unless otherwise specified, the effective date is the date of service.*

Attachment – Recurring Update Notification

Pub. 100-04	Transmittal: 1384	Date: November 30, 2007	Change Request: 5800

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

EFFECTIVE DATE: January 1, 2008

IMPLEMENTATION DATE: January 7, 2008

I. GENERAL INFORMATION

A. 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 Remittance Advice Remark Codes (RARCs) are required in the remittance advice transaction.

X12N 835 Health Care Remittance Advice Remark Codes

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 Implementation Guide (IG). 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 payers for new codes and modification/deactivation of existing codes. Additions, deletions, and modifications to the code list resulting from non-Medicare requests may not impact Medicare. Recently, a number of entities including Medicare requested new remark codes as a response to modification of 5 reason codes – a remark code must be used when using one of the Claim Adjustment Reason Codes 16, 17, 96, 125, and A1. Contractors may pick one of those newly created remark codes for Medicare use, if appropriate.

Remark and reason code changes that impact Medicare are usually requested by CMS staff in conjunction with a policy change. Contractors are notified about these changes in the corresponding instructions from the specific CMS component which 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, contractors shall use the modified code even though the modification was not initiated by Medicare. **Contractors shall stop using codes that have been deactivated on or before the effective date specified in the comment section (as posted on the WPC Web site) 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 WPC web site because the code list is updated 3 times a year and does not align with the Medicare release schedule. Please note that you shall accept a deactivated reason code used in derivative messages even after the code is deactivated. Medicare contractors shall not use any deactivated code past the deactivation date whether the deactivation is requested by Medicare or any other entity. The complete list of remark codes is available at: http://www.wpc-edi.com/codes

The list is updated 3 times a year. **Please note that in order to synchronize with the CARC update schedule, the RARC list will be updated in early November, March, and July instead of the current**

schedule of early December, April, and August. By January 1, 2008 you must complete entry of all applicable code text changes and new codes, and terminate use of deactivated codes.

You must use the latest approved and valid codes in your 835, corresponding standard paper remittance advice, and coordination of benefits transactions. CMS has developed a new Web site to help navigate the RARC database more easily. A tool is provided to help search if you are looking for a specific category of code. At this site you can find some other information that is also available from the WPC Web site. The new Web site address is: http://www.cmsremarkcodes.info/

NOTE I: This Web site is not replacing the WPC Web site as the official site where the most current RARC list resides. If there is any discrepancy, always use the list posted at the WPC Web site.

NOTE II: Some remark codes may only provide general information that may not necessarily supplement the specific explanation provided through a reason code and in some cases another/other remark code(s) for an adjustment. Codes that are "Informational" 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 about adjudication (like appeal rights) needs to be communicated but not as default codes. A number of remark codes have been identified as "Informational" and have been modified by adding the word "Alert" in front of the text. These codes may be used without any CARC explaining a specific adjustment.

Remittance Advice Remark Code changes

New Codes

Code	Current Narrative	Medicare Initiated
N388	Missing/incomplete/invalid prescription number Note: (New Code 8/1/07)	YES
N389	Duplicate prescription number submitted. Note: (New Code 8/1/07)	YES
N390	This service cannot be billed separately. Note: (New Code 8/1/07)	YES
N391	Missing emergency department records. Note: (New Code 8/1/07)	NO
N392	Incomplete/invalid emergency department records. Note: (New Code 8/1/07)	NO
N393	Missing progress notes or report. Note: (New Code 8/1/07)	NO
N394	Incomplete/invalid progress notes or report. Note: (New Code 8/1/07)	NO
N395	Missing laboratory report. Note: (New Code 8/1/07)	NO
N396	Incomplete/invalid laboratory report. Note: (New Code 8/1/07)	NO
N397	Benefits are not available for incomplete service(s)/undelivered item(s). Note: (New Code 8/1/07)	NO

N398	Missing elective consent form. Note: (New Code 8/1/07)	NO
N399	Incomplete/invalid elective consent form. Note: (New Code 8/1/07)	NO
N400	Alert: Electronically enabled providers should submit claims electronically. Note: (New Code 8/1/07)	NO
N401	Missing periodontal charting. Note: (New Code 8/1/07)	NO
N402	Incomplete/invalid periodontal charting. Note: (New Code 8/1/07)	NO
N403	Missing facility certification. Note: (New Code 8/1/07)	NO
N404	Incomplete/invalid facility certification. Note: (New Code 8/1/07)	NO
N405	This service is only covered when the donor's insurer(s) do not provide coverage for the service. Note: (New Code 8/1/07)	NO
N406	This service is only covered when the recipient's insurer(s) do not provide coverage for the service. Note: (New Code 8/1/07)	NO
N407	You are not an approved submitter for this transmission format. Note: (New Code 8/1/07)	YES
N408	This payer does not cover deductibles assessed by a previous payer. Note: (New Code 8/1/07)	NO
N409	This service is related to an accidental injury and is not covered unless provided within a specific time frame from the date of the accident. Note: (New Code 8/1/07)	NO
N410	This is not covered unless the prescription changes. Note: (New Code 8/1/07)	NO
N411	This service is allowed one time in a 6-month period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.) Note: (New Code 8/1/07)	NO
N412	This service is allowed 2 times in a 12-month period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.) Note: (New Code 8/1/07)	NO
N413	This service is allowed 2 times in a benefit year. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.) Note: (New Code 8/1/07)	NO
N414	This service is allowed 4 times in a 12-month period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.) Note: (New Code 8/1/07)	NO

N415	This service is allowed 1 time in an 18-month period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.) Note: (New Code 8/1/07)	NO
N416	This service is allowed 1 time in a 3-year period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.) Note: (New Code 8/1/07)	NO
N417	This service is allowed 1 time in a 5-year period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.) Note: (New Code 8/1/07)	NO
N418	Misrouted claim. See the payer's claim submission instructions. Note: (New Code 8/1/07)	NO
N419	Claim payment was the result of a payer's retroactive adjustment due to a retroactive rate change. Note: (New Code 8/1/07)	NO
N420	Claim payment was the result of a payer's retroactive adjustment due to a Coordination of Benefits or Third Party Liability Recovery. Note: (New Code 8/1/07)	NO
N421	Claim payment was the result of a payer's retroactive adjustment due to a Peer Review Organization decision. Note: (New Code 8/1/07)	NO
N422	Claim payment was the result of a payer's retroactive adjustment due to a payer's contract incentive program. Note: (New Code 8/1/07)	NO
N423	Claim payment was the result of a payer's retroactive adjustment due to a non standard program. Note: (New Code 8/1/07)	NO
N424	Patient does not reside in the geographic area required for this type of payment. Note: (New Code 8/1/07)	YES
N425	Statutorily excluded service(s). Note: (New Code 8/1/07)	YES
N426	No coverage when self-administered. Note: (New Code 8/1/07)	YES
N427	Payment for eyeglasses or contact lenses can be made only after cataract surgery. Note: (New Code 8/1/07)	YES
N428	Service/procedure not covered when performed in this place of service. Note: (New Code 8/1/07)	YES
N429	This is not covered since it is considered routine. Note: (New Code 8/1/07)	YES

Modified Codes

Code	Current Modified Narrative	Modification Date(s)

M27	**Alert:** The patient has been relieved of liability of payment of these items and services under the limitation of liability provision of the law. The provider is ultimately liable for the patient's waived charges, including any charges for coinsurance, since the items or services were not reasonable and necessary or constituted custodial care, and you knew or could reasonably have been expected to know, that they were not covered. You may appeal this determination. You may ask for an appeal regarding both the coverage determination and the issue of whether you exercised due care. The appeal request must be filed within 120 days of the date you receive this notice. You must make the request through this office.	Note: (Modified 10/1/02, 8/1/05, 4/1/07, 8/1/07)
M70	**Alert:** The NDC code submitted for this service was translated to a HCPCS code for processing, but please continue to submit the NDC on future claims for this item.	Note: (Modified 4/1/2007, 8/1/07)
MA14	**Alert:** The patient is a member of an employer-sponsored prepaid health plan. Services from outside that health plan are not covered. However, as you were not previously notified of this, we are paying this time. In the future, we will not pay you for non-plan services.	Note: (Modified 4/1/07, 8/1/07)
MA62	**Alert:** This is a telephone review decision.	Note: (Modified 4/1/07, 8/1/07)
N12	Policy provides coverage supplemental to Medicare. As the member does not appear to be enrolled in the applicable part of Medicare, the member is responsible for payment of the portion of the charge that would have been covered by Medicare.)	Note: (Modified 8/1/07)
N84	**Alert:** Further installment payments are forthcoming.	Note: (Modified 4/1/07, 8/1/07)
N85	**Alert:** This is the final installment payment.	Note: (Modified 4/1/07, 8/1/07)
N129	Not eligible due to the patient's age.	Note: (New Code 10/31/02, Modified 8/1/07)

Deactivated Codes

None.

X12 N 835 Health Care Claim Adjustment Reason Codes

A national code maintenance committee maintains the health care Claim Adjustment Reason Codes (RARCs). 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 3 times a year around early November, March, and July after each X12 trimester meeting. To access the list select http://www.wpc-edi.com/codes. Select Claim Adjustment Reason Codes from the pull down menu. All reason code changes approved up to

June 2007 were included in CR 5721 that you have implemented in October. Reason code changes that will be approved in the next meeting will be in the next code update CR to be implemented in April.

The regular code update notification will establish the deadline for deactivation and modification for Medicare contractors. **The Medicare deadline could be earlier than the date specified in the Washington Publishing Company (WPC) posting.** But other payers may continue using these deactivated/modified codes till the stop date. Also a deactivated code may be used by Medicare and other payers in derivative business messages.

New Codes: None

Modified Codes: None

Deactivated Codes: None

Reminder: The following code has been deactivated earlier (and included in CR 5721) but will take effect

in January 2008.

A2	Contractual adjustment. **NOTES**: Use Code 45 with Group Code 'CO' or use another appropriate specific adjustment code. The "Stop" date of 1/1/2008 may change.	Start: 01/01/1995 | Stop: **01/01/2008** | Last Modified: 02/28/2007

B. Policy: For transaction 835 (Health Care Claim Payment/Advice) and standard paper remittance advice, there are two code sets – Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) – that must be used to report payment adjustments, appeal rights, and related information. Additionally, for transaction 837 COB, CARC must be used. These code sets are updated on a regular basis. Medicare contractors must use only currently valid codes, and make the necessary changes on a regular basis as per this recurring code update CR or the specific CR that describes the change in policy that resulted in the code change.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
5800.1	A/B MACs, carriers, DME MACs, FIs, and RHHIs shall update remark codes that have been modified and apply to Medicare by January 1, 2008.	X	X	X	X	X					
5800.2	A/B MACs, carriers, DME MACs, FIs, and RHHIs shall update remark codes to include new codes that apply to Medicare by January 1, 2008.	X	X	X	X	X					

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
5800.3	A/B MACs, carriers, DME MACs, FIs, and RHHIs shall update reason and remark codes that have been deactivated whether they apply to Medicare or not by January 1, 2008.	X	X	X	X	X					
5800.4	VMS shall update the Medicare Remit Easy Print software to include the most current RARC list available from the following Web site: http://www.wpc-edi.com/codes (Note: This update is provided in a separate file.)								X		
5800.5	A/B MACs, carriers, and DME MACs shall notify the users that the code update file must be downloaded to be used in conjunction with the current software. (Note: The software will be updated if there is any enhancement to be implemented. If there is no enhancement needed, the code update file will be used with the existing software).	X	X		X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
5800.6	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X	X	X	X					

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:

X-Ref Requirement Number	Recommendations or other supporting information:
	N/A

B. For all other recommendations and supporting information, use this space:

N/A

V. CONTACTS

Pre-Implementation Contact(s): Sumita Sen, 410-786-5755, sumita.sen@cms.hhs.gov

Post-Implementation Contact(s): Sumita Sen, 410-786-5755, sumita.sen@cms.hhs.gov

VI. FUNDING

A. ***For Fiscal Intermediaries and Carriers*****:**
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

B. ***For Medicare Administrative Contractors (MAC)*****:**
The Medicare Administrative Contractor (MAC) is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as changes to the MAC Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts specified in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.