

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1734	Date: May 15, 2009
	Change Request 6453

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

I. SUMMARY OF CHANGES: This Change Request (CR) instructs contractors to add or modify reason and remark codes that have been added or modified since the release of transmittal 1674 dated January 30, 2009, (CR 6336). This CR also instructs Shared System Maintainers (SSMs) to deactivate the codes that have been deactivated since CR 6336, and instructs SSMs and CEDI to accept deactivated codes in derivative messages. Additionally this CR instructs VIPs to update Medicare Remit Easy Print (MREP). This Recurring Update Notification applies to Chapter 22, Section 60.1.

NEW / REVISED MATERIAL

EFFECTIVE DATE: *July 1, 2009

IMPLEMENTATION DATE: July 6, 2009

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

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

EFFECTIVE DATE: July 1, 2009

IMPLEMENTATION DATE: July 6, 2009

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 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.

The CARC and RARC changes that impact Medicare are usually requested by CMS staff in conjunction with a policy change. Contractors and Shared System Maintainers (SSMs) 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. Shared System Maintainers have the responsibility to implement code deactivation making sure that any deactivated code is not used in original business messages, but the deactivated code in derivative messages is allowed. 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 may 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 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 Medicare contractors and the Shared System Maintainers if no other specific CR has been issued by another CMS component. Medicare contractors shall not use any deactivated reason or remark code past the deactivation date whether the deactivation is requested by Medicare or any other entity. Lists of all deactivated and scheduled to be deactivated CARCs and RARCs are available at the WPC Web site:

<http://www.wpc-edi.com/Codes>

Claim Adjustment Reason Codes:

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 3 times a year around early November, March, and July. To access the list select:

<http://www.wpc-edi.com/Codes>

The new codes become effective when approved. Any modification or deactivation becomes effective on April 1 or July 1 or October 1 or January 1. The effective date for a modification may also be the date when it's approved if the requester can provide enough justification to have the modification become effective earlier than the next quarterly release date. The committee that maintains the CARC list has recently made a decision that any deactivation or modification (see above for exception scenario) will match the quarterly release effective dates rather than strict 6 months from the approval date to avoid any issue for payers (e.g., Medicare) that can implement any change only at the start of a quarter.

New Codes – CARC:

Code	Current Narrative	Effective Date per WPC Posting
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.	1/25/2009
230	No available or correlating CPT/HCPCS code to describe this service, Note: Used only by Property and Casualty	1/25/2009

Modified Codes – CARC:

Code	Current Narrative	Effective Date per WPC posting
187	Health Savings account payments. This change to be effective 10/1/2009: Consumer Spending Account payments (includes but is not limited to Flexible Spending Account, Health Savings Account, Health Reimbursement Account, etc.)	1/25/2009

Deactivated Codes – CARC

Code	Current Narrative	Effective Date
17 *	Requested information was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	7/1/2009
156	Flexible spending account payments. Note: Use code 187.	10/1/2009

*Also see CR 6336. CARC 17 is being replaced with 2 new CARCs:

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 Remittance Advice Remark Code or NCPDP Reject Reason Code.)

227: Information requested from the patient/insured/responsible party was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

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 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. 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. Shared System Maintainers have the responsibility to implement code (both CARC and RARC) deactivation making sure that any deactivated code is not used in original business messages, but the deactivated code in derivative messages is allowed. **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. Medicare contractors shall not use any deactivated reason and/or remark 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>

RARC list is updated 3 times a year – in early March, July, and November although the Committee meets every month. The RARC Committee has established the following schedule:

Request received in October – January:

Published in early March.

Deactivation becomes effective in October

Any new code or modification become effective when published

Request received in February – May:

Published in early July

Deactivation becomes effective in January

Any new code or modification become effective when published

Request received in June – September:

Published in early November

Deactivation becomes effective in April

Any new code or any modification becomes effective when published

The Centers for Medicare and Medicaid Services (CMS) will publish the recurring code update CR 4 times a year with implementation in January, April, July and October. As mentioned earlier, specific CMS components may publish additional CRs instructing contractors to use specific RARCs and establishing implementation date that may differ from the implementation date mentioned in the recurring code update CR. If there is any difference in the implementation dates, the contractors are to implement on the earlier date of the two.

By July 6, 2009 contractors shall complete entry of all applicable code text changes and new codes, and the Shared System Maintainers shall implement all code deactivations. Contractors must use the latest approved and valid codes in the 835, corresponding Standard Paper Remittance (SPR) 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 codes. At this site you can find some other information that is also available from the WPC Web site. The 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 a monetary adjustment. Codes that are “Informational” will have “Alert” in the text to identify them as informational rather than explanatory codes. These “Informational” codes may be used without any CARC explaining a specific 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 when a RARC is required with a CARC -16, 96, 125, 148, 226, 227, and A1.**

NOTE III: This recurring CR lists only the changes that have been approved since the last code update CR, and does not provide a complete list of new or modified codes. You must get the complete list for both CARC and RARC from the WPC web site. **A deactivation will be repeated if more than one CR is published before a code deactivation becomes effective e.g., CARC 17 has been included in CR 6336, and is being included in this CR.**

New Codes – RARC:

Code	Current Narrative	Medicare Initiated
N516	Records indicate a mismatch between the submitted NPI and EIN.	NO
N517	Resubmit a new claim with the requested information	YES
N518	No separate payment for accessories when furnished for use with oxygen equipment.	YES

Modified Codes – RARC:

Code	Current Narrative	Medicare Initiated
M6	Alert: You must furnish and service this item for any period of medical need for the remainder of the reasonable useful lifetime of the equipment. Start: 01/01/1997 Last Modified: 03/01/2009 Notes: (Modified 4/1/07, 3/1/2009)	YES
N109	This claim/service was chosen for complex review and was denied after reviewing the medical records. Start: 02/28/2002 Last Modified: 03/01/2009 Notes: (Modified 3/1/2009)	YES
N387	Alert: Submit this claim to the patient's other insurer for potential payment of supplemental benefits. We did not forward the claim information. Start: 04/01/2007 Last Modified: 03/01/2009 Notes: (Modified 3/1/2009)	YES

Deactivated Codes – RARC

Code	Current Narrative	Medicare Initiated
N515	Alert: Submit this claim to the patient's other insurer for potential payment of supplemental benefits. We did not forward the claim information. (use N387 instead) Start: 11/01/2008 Stop: 10/01/2009	YES

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 3 times a year on a regular basis. Medicare contractors shall report only currently valid codes in both the remittance advice and COB Claim transaction, and shall allow deactivated CARC and RARC in derivative messages when certain conditions are met (see BR segment for explanation of conditions). Shared System Maintainers and contractors must 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	D M E	F I	C A R R I E R	R H H I	Shared-System Maintainers				O T H E R
							F I S S	M C S	V I P S	C W F	
6453.1	A/B MACs, carriers, DME MACs, FIs, and RHHIs shall update reason and remark codes that have been modified and apply to Medicare by July 6, 2009.	X	X	X	X	X					
6453.2	A/B MACs, carriers, DME MACs, FIs, and RHHIs shall update reason and remark codes to include new codes that apply to Medicare by July 6, 2009.	X	X	X	X	X					
6453.3	FISS, MCS, and VIPs shall make necessary programming changes so that no deactivated reason and remark code is reported in the remittance advice and no deactivated reason code is reported in the COB claim by July 6, 2009.						X	X	X		
6453.4	FISS, MCS, VIPs shall update any crosswalk between the standard reason and remark codes and the shared system internal codes provided to the contractors and make any deactivated standard code unavailable for use by the contractors.						X	X	X		
6453.5	FISS, MCS, and CEDI shall make necessary programming changes so that deactivated reason and remark codes are allowed in derivative messages even after the deactivation effective date when: <ul style="list-style-type: none"> • Medicare is not primary; and • the COB claim is received after the deactivation effective date; and • the date in DTP03 in Loop 2430 or 2330B in COB 837 transaction is less than the deactivation effective date as posted on the WPC web site. 						X	X			CEDI
6453.6	FISS, MCS, and VIPs shall make necessary programming changes so that deactivated reason and remark codes are allowed in derivative messages even after the deactivation effective date in a Reversal and Correction situation when a value of 22 in CLP02 identifies the claim to be a corrected claim.						X	X	X		
6453.7	VIPs shall update the Medicare Remit Easy Print (MREP) software to include the most current CARC and RARC lists available from the following Web site: http://www.wpc-edi.com/codes (Note: This update is provided in a separate file since April, 2008.)								X		

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B	D M E	F I	C A R R I E R	R H H I	Shared-System Maintainers				OT H E R
		M A C	M A C		I E R		F I S S	M C S	V M S	C W F	
6453.8	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 updated MREP software.	X	X		X						CEDI
6453.9	A/B MACs, carriers, DME MACs, FIs, and RHHIs shall replace CARC 17 with either CARC 226 or CARC 227 as appropriate.	X	X	X	X	X					
6453.10	A/B MACs, carriers, DME MACs, FIs, and RHHIs shall make sure that at least one explanatory RARC is used with CARCs 16, 96, 125, 148, 226, 227, and A1. "Informational" RARCs with "Alert" in the text cannot be used as the required RARC, but can be used as additional RARC(s) with these generic CARCs. Note: This BR does not apply to any contractor who has already changed to using at least one non-Informational RARC with CARCs 16, 96, 148, 125, 226, 227, and A1.	X	X	X	X	X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B	D M E	F I	C A R R I E R	R H H I	Shared-System Maintainers				OT H E R
		M A C	M A C		I E R		F I S S	M C S	V M S	C W F	
6453.11	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	X	X	X	X	X					CEDI

Number	Requirement	Responsibility (place an "X" in each applicable column)								
		A / B M A C	D M E M A C	F I M A C	C A R E R	R H I I S S	Shared-System Maintainers			
						F I S S	M C S	V M S	C W F	
	supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.									

IV. SUPPORTING INFORMATION

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

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

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

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

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or 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.