CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1634	**Date: November 14, 2008**
	Change Request 6229

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

I. SUMMARY OF CHANGES: This CR instructs contractors to add or modify reason and remark codes that have been added or modified since CR 6109 (Transmittal 1563 published on July 25, 2008). This CR also instructs Shared System Maintainers (SSMs) to deactivate the codes that have been deactivated since CR 6109 (Transmittal 1563 published on July 25, 2008). Additionally this CR instructs VIPs to update Medicare Remit Easy Print (MREP) software to include the reason and remark code changes, and perform analysis to identify the discrepancies between Electronic Remittance Advice (ERA) and the remittance advice generated using the Medicare Remit Easy Print software. The attached Recurring Update Notification applies to Chapter 22, Section 60.1.

NEW / REVISED MATERIAL
EFFECTIVE DATE: *January 1, 2009
IMPLEMENTATION DATE: January 5, 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

Pub. 100-04	Transmittal: 1634	Date: November 14, 2008	Change Request: 6229

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

EFFECTIVE DATE: January 1, 2009

IMPLEMENTATION DATE: January 5, 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 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 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 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 three 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 complete list of remark codes is available at:

http://www.wpc-edi.com/codes

The RARC list is updated three 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 October

Any new code or modification become effective when published

Request received in February – May:

Published in early July

Deactivation becomes effective January

Any new code or modification become effective when published

Request received in June – September:

Published in early November

Deactivation becomes effective April

Any new code or any modification becomes effective when published

The Centers for Medicare and Medicaid Services (CMS) publishes the recurring code update CR three times a year with implementation in January, April, 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 January 5, 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.

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 when a RARC is required with a CARC -16, 17, 96, 125, and A1.

Remittance Advice Remark Code changes

New Codes:

Code	Current Narrative	Medicare Initiated
N434	Missing/Incomplete/Invalid Present on Admission indicator. Start: 7/1/2008	
N435	Exceeds number/frequency approved /allowed within time period without support documentation. Start: 7/1/2008	
N436	The injury claim has not been accepted and a mandatory medical reimbursement has been made. Start: 7/1/2008	
N437	Alert: If the injury claim is accepted, these charges will be reconsidered. Start: 7/1/2008	
N438	This jurisdiction only accepts paper claims Start: 7/1/2008	
N439	Missing anesthesia physical status report/indicators. Start: 7/1/2008	
N440	Incomplete/invalid anesthesia physical status report/indicators. Start: 7/1/2008	
N441	This missed appointment is not covered. Start: 7/1/2008	
N442	Payment based on an alternate fee schedule. Start: 7/1/2008	
N443	Missing/incomplete/invalid total time or begin/end time. Start: 7/1/2008	
N444	Alert: This facility has not filed the Election for High Cost Outlier form with the Division of Workers' Compensation. Start: 7/1/2008	
N445	Missing document for actual cost or paid amount. Start: 7/1/2008	

N446	Incomplete/invalid document for actual cost or paid amount. Start: 7/1/2008	
N447	Payment is based on a generic equivalent as required documentation was not provided. Start: 7/1/2008	
N448	This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement Start: 7/1/2008	
N449	Payment based on a comparable drug/service/supply. Start: 7/1/2008	
N450	Covered only when performed by the primary treating physician or the designee. Start: 7/1/2008	
N451	Missing Admission Summary Report. Start: 7/1/2008	
N452	Incomplete/invalid Admission Summary Report. Start: 7/1/2008	
N453	Missing Consultation Report. Start: 7/1/2008	
N454	Incomplete/invalid Consultation Report. Start: 7/1/2008	
N455	Missing Physician Order. Start: 7/1/2008	
N456	Incomplete/invalid Physician Order. Start: 7/1/2008	
N457	Missing Diagnostic Report. Start: 7/1/2008	
N458	Incomplete/invalid Diagnostic Report. Start: 7/1/2008	
N459	Missing Discharge Summary. Start: 7/1/2008	
N460	Incomplete/invalid Discharge Summary. Start: 7/1/2008	
N461	Missing Nursing Notes. Start: 7/1/2008	
N462	Incomplete/invalid Nursing Notes. Start: 7/1/2008	
N463	Missing support data for claim. Start: 7/1/2008	
N464	Incomplete/invalid support data for claim. Start: 7/1/2008	
N465	Missing Physical Therapy Notes/Report. Start: 7/1/2008	
N466	Incomplete/invalid Physical Therapy Notes/Report. Start: 7/1/2008	
N467	Missing Report of Tests and Analysis Report. Start: 7/1/2008	

N468	Incomplete/invalid Report of Tests and Analysis Report. Start: 7/1/2008	
N469	Alert: Claim/Service(s) subject to appeal process, see section 935 of Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). Start: 7/1/2008	YES
N470	This payment will complete the mandatory medical reimbursement limit. Start: 7/1/2008	
N471	Missing/incomplete/invalid HIPPS Rate Code. Start: 7/1/2008	
N472	Payment for this service has been issued to another provider. Start: 7/1/2008	
N473	Missing certification. Start: 7/1/2008	
N474	Incomplete/invalid certification Start: 7/1/2008	
N475	Missing completed referral form. Start: 7/1/2008	
N476	Incomplete/invalid completed referral form Start: 7/1/2008	
N477	Missing Dental Models. Start: 7/1/2008	
N478	Incomplete/invalid Dental Models Start: 7/1/2008	
N479	Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer). Start: 7/1/2008	
N480	Incomplete/invalid Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer). Start: 7/1/2008	
N481	Missing Models. Start: 7/1/2008	
N482	Incomplete/invalid Models Start: 7/1/2008	
N483	Missing Periodontal Charts. Start: 7/1/2008	
N484	Incomplete/invalid Periodontal Charts Start: 7/1/2008	
N485	Missing Physical Therapy Certification. Start: 7/1/2008	
N486	Incomplete/invalid Physical Therapy Certification. Start: 7/1/2008	
N487	Missing Prosthetics or Orthotics Certification. Start: 7/1/2008	
N488	Incomplete/invalid Prosthetics or Orthotics Certification Start: 7/1/2008	

N489	Missing referral form. Start: 7/1/2008	
N490	Incomplete/invalid referral form Start: 7/1/2008	
N491	Missing/Incomplete/Invalid Exclusionary Rider Condition. Start: 7/1/2008	
N492	Alert: A network provider may bill the member for this service if the member requested the service and agreed in writing, prior to receiving the service, to be financially responsible for the billed charge. Start: 7/1/2008	
N493	Missing Doctor First Report of Injury. Start: 7/1/2008	
N494	Incomplete/invalid Doctor First Report of Injury. Start: 7/1/2008	
N495	Missing Supplemental Medical Report. Start: 7/1/2008	
N496	Incomplete/invalid Supplemental Medical Report. Start: 7/1/2008	
N497	Missing Medical Permanent Impairment or Disability Report. Start: 7/1/2008	
N498	Incomplete/invalid Medical Permanent Impairment or Disability Report. Start: 7/1/2008	
N499	Missing Medical Legal Report. Start: 7/1/2008	
N500	Incomplete/invalid Medical Legal Report. Start: 7/1/2008	
N501	Missing Vocational Report. Start: 7/1/2008	
N502	Incomplete/invalid Vocational Report. Start: 7/1/2008	
N503	Missing Work Status Report. Start: 7/1/2008	
N504	Incomplete/invalid Work Status Report. Start: 7/1/2008	

Modified Codes

Code	Current Modified Narrative	Last Modified
M29	Missing operative note/report.	7/1/08
N10	Payment based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor.	7/1/08

N26	Missing itemized bill/statement.	7/1/08
N40	Missing radiology film(s)/image(s).	7/1/08
N130	Alert: Consult plan benefit documents/guidelines for information about restrictions for this service.	7/1/08
N209	Missing/incomplete/invalid taxpayer identification number (TIN).	7/1/08
N232	Incomplete/invalid itemized bill/statement.	7/1/08
N233	Incomplete/invalid operative note/report.	7/1/08
N242	Incomplete/invalid radiology film(s)/image(s).	7/1/08
N350	Missing/incomplete/invalid description of service for a Not Otherwise Classified (NOC) code or for an Unlisted/By Report procedure.	7/1/08
N367	Alert: The claim information has been forwarded to a Consumer Spending Account processor for review; for example, flexible spending account or health savings account.	7/1/08
N390	This service/report cannot be billed separately	7/1/08
N393	Missing progress notes/report	7/1/08
N394	Incomplete/invalid progress notes/report.	7/1/08

Deactivated Codes

None

Lists of all deactivated and scheduled to be deactivated RARCs are available at the WPC Web site.

X12 N 835 Health Care 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 three times a year around early November, March, and July. To access the list select:

http://www.wpc-edi.com/codes.

Select Claim Adjustment Reason Codes from the pull down menu.

The following schedule has been developed for deactivations and modifications:

Decision Made	Published	Effective Date
Jan/Feb	Early March	October 1
June	Early July	January 1
Sep/Oct	Early November	April 1

The new codes become effective when approved.

A modification may also be effective when approved if the requester provides justification for an earlier implementation/effective date for the change. The regular code update CR will establish the implementation date for Medicare contractors and the Shared System Maintainers if there is no other specific CR has been issued. Medicare contractors shall not use any deactivated reason 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 are available at the WPC Web site.

New Codes:

Code	Current Narrative	Implementation Date
222	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific. Start Date: 6/1/2008	1/5/2009
223	Adjustment code for mandated federal, state or local law/regulation that is not already covered by another code and is mandated before a new code can be created. Start Date: 6/1/2008	1/5/2009
224	Patient identification compromised by identity theft. Identity verification required for processing this and future claims. Start Date: 6/1/2008	1/5/2009
225	Penalty or Interest Payment by Payer (Only used for plan to plan encounter reporting within the 837) Start Date: 6/1/2008	1/5/2009

Note: Codes 223 and 224 are Medicare initiated

Modified Codes:

Code	Modified Narrative	Implémentation Date

60	Charges for outpatient services with this proximity to inpatient services are not covered. This change to be effective 1/1/2009: Charges for outpatient services are not covered when performed within a period of time prior to or after inpatient services.	1/5/2009

Deactivated Codes:

Code	Current Narrative	Implementation Date
D22	Reimbursement was adjusted for the reasons to be provided in separate correspondence. (Note: To be used for Workers' Compensation only) - Temporary code to be added for timeframe only until 01/01/2009. Another code to be established and/or for 06/2008 meeting for a revised code to replace or strategy to use another existing code Start: 01/27/2008 | Stop: 01/01/2009	1/1/2009

The Code Committee also reactivated CARC 207

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 report only currently valid codes in both the remittance advice and COB Claim transaction. 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 MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER CEDI
							FISS	MCS	VMS	CWF	
6229.1	A/B MACs, carriers, DME MACs, FIs, and RHHIs shall update reason and remark codes that have been modified	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 CEDI
							FISS	MCS	VMS	CWF	
	and apply to Medicare by January 5, 2009.										
6229.2	A/B MACs, carriers, DME MACs, FIs, and RHHIs shall update reason and remark codes to include new codes that apply to Medicare by January 5, 2009.	X	X	X	X	X					
6229.3	FISS, MCS, and VMS 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 January 5, 2009.						X	X	X		
6229.4	FISS, MCS, and CEDI shall make necessary programming changes by January 5, 2009, so that deactivated reason and remark codes are allowed in derivative messages even after the deactivation effective date when: ● 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			X
6229.5	FISS, MCS, and VMS shall make necessary programming changes by January 5, 2009, 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		
6229.6	VMS shall update the Medicare Remit Easy Print 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 starting in April, 2008.)								X		
6229.7	A/B MACs, carriers, and DME MACs shall notify the	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 CEDI
							FISS	MCS	VMS	CWF	
	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).										
6229.8	A/B MACs, carriers, DME MACs, FIs, and RHHIs shall make sure that at least one explanatory RARC is used with CARCs 16, 17, 96, 125, and A1. "Informational" RARCs with "Alert" in the text can not be used as the required RARC, but can be used as additional RARC(s) with these generic CARCs.	X	X	X	X	X					
6229.9	VMS shall perform analysis to identify discrepancies between Electronic Remittance Advice (ERA) and the remittance advice generated using the Medicare Remit Easy Print software.								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	
6229.10	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.	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	
	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.										

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), Carriers, and Regional Home Health Carriers (RHHIs)* use only one of the following statements:

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),* use the following statement:

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.