CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2372	**Date: December 22, 2011**
	Change Request 7683

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

I. SUMMARY OF CHANGES: This purpose of this Change Request (CR) is to instruct the contractors and the Shared System Maintainers (SSMs) to make programming changes to incorporate new, modified, and deactivated Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) that have been added since the last recurring code update CR. It also instructs Fiscal Intermediary Standard System (FISS) and VIPs Medicare System (VMS) to update PC Print and Medicare Remit Easy Print (MREP) software.

EFFECTIVE DATE: April 1, 2012
IMPLEMENTATION DATE: April 2, 2012

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:
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.

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: 2372	Date: December 22,2011	Change Request: 7683

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

Effective Date: April 1, 2012
Implementation Date: April 2, 2012

GENERAL INFORMATION

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 that implements the policy change, in addition to the regular code update notification. If a modification has been initiated by an entity other than CMS for a code currently used by Medicare, contractors must either use the modified code or another code if the modification makes the modified code inappropriate to explain the specific reason for adjustment. **SSMs 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. SSMs must make sure that Medicare does not report any deactivated code on or before the effective date for deactivation as posted on the WPC Web site.** 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 the WPC Web site because the code list is updated three times a year and may not align with the Medicare release schedule. **(Note: A deactivated code used in derivative messages must be accepted even after the code is deactivated if the deactivated code was used before the deactivation date by a payer who adjudicated the claim before Medicare.)** Medicare contractors must stop using any deactivated reason and/or remark code past the deactivation date whether the deactivation is requested by Medicare or any other entity. **The regular code update Change Request (CR) will establish the implementation date for all modifications, deactivations, and any new code for Medicare contractors and the SSMs (see below table for exceptions). If another specific CR has been issued by another CMS component with a different implementation date, the earlier of the two dates will apply for Medicare implementation**. If any new or modified code has an effective date past the implementation date specified in this CR, contractors must implement on the date specified on the WPC Web site.

See below for code change implementation exceptions if the implementation date in this recurring CR (or any other CMS CR) does not match the effective date specified at WPC Web site:

Type of Change	Implementation Date	Responsible Party

Deactivation	On or before the date posted at WPC Web site	SSMs
Modification	On the date posted at WPC Web site	Contractors/SSMs
New	On or after the date posted at WPC Web site	Contractors/SSMs

The discrepancy between the dates may arise because the WPC Web site gets updated only 3 times a year and may not match the CMS release schedule.

This recurring CR lists only the changes that have been approved since the last code update CR (CR 7514 Transmittal 2304), and does not provide a complete list of codes in these two code sets. You must get the complete list for both CARC and RARC from the WPC Web site that is updated three times a year – around March 1, July 1, and November 1 – to get the comprehensive lists for both code sets, but the implementation date for any new or modified or deactivated code for Medicare contractors is established by this recurring code update CR published three or four times a year according to the Medicare release schedule (see above for exception).

WPC Web site address: **http://www.wpc-edi.com/Reference**

The WPC Web site has four listings available for both CARC and RARC:

All: All codes including deactivated and to be deactivated codes are included in this listing.
To Be Deactivated: Only codes to be deactivated at a future date are included in this listing.
Deactivated: Only codes with prior deactivation effective date are included in this listing.
Current: Only currently valid codes are included in this listing.

NOTE I: In case of any discrepancy in the code text as posted on WPC Web site and as reported in any CR, the WPC version should be implemented.

NOTE II: This recurring Code Update CR lists only the changes approved since the last recurring Code Update CR once. If any modification becomes effective at a future date, contractors must make sure that they update on the quarterly release date that matches the effective date as posted on the WPC Web site.

Claim Adjustment Reason Code (CARC):

A national code maintenance committee maintains the health care Claim Adjustment Reason Codes (CARCs). The Committee meets at the beginning of each X12 trimester meeting (January/February, June and September/October) and makes decisions about additions, modifications, and retirement of existing reason codes. The updated list is posted three times a year around early March, July, and November. To access the list go to: **http://www.wpc-edi.com/Reference**

The new codes usually become effective when approved unless mentioned otherwise. Any modification or deactivation becomes effective on a future date to provide lead time for implementing necessary programming changes. Exception: The effective date for a modification may be as early as the approval or publication date if the requester can provide enough justification to have the modification become effective earlier than a future date. A health plan may decide to implement a code deactivation before the actual effective date posted on WPC Web site as long as the deactivated code is allowed to come in on Coordination of Benefits (COB) claims if the previous payer(s) has (have) used that code prior to the deactivation date. In most cases Medicare will stop using a deactivated code before the deactivation becomes effective per the WPC Web site to accommodate the Medicare release schedule.

The following new Claim Adjustment Reason Codes were approved by the Code Committee in October, and must be implemented, if appropriate, by April 2, 2012.

New Codes – CARC:

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

Modified Codes – CARC:

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

Deactivated Codes – CARC:

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

Remittance Advice Remark Codes (RARC):

CMS is the national maintainer of the remittance advice remark code list. This code list is used by reference in the ASC X12 N transaction 835 (Health Care Claim Payment/Advice) version 004010A1 and 005010A1 Implementation Guide (IG)/Technical Report (TR) 3. Under HIPAA, all payers, including Medicare, have to use reason and remark codes approved by X12 recognized code set maintainers instead of proprietary codes to explain any adjustment in the claim payment. CMS as the X12 recognized maintainer of RARCs receives requests from Medicare and non- Medicare entities for new codes and modification/deactivation of existing codes. Additions, deletions, and modifications to the code list resulting from non-Medicare requests may or may not impact Medicare. Remark and reason code changes that impact Medicare are usually requested by CMS staff in conjunction with a policy change. 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 must 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. The complete list of remark codes is available at: **http://www.wpc-edi.com/Reference**

RARC list is updated three times a year – in early March, July and November although the RARC 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 July
Any new code or any modification becomes effective when published

NOTE: Exception to the above schedule may be approved by the RARC Committee if enough justification is provided by the requester for a different effective date.

This recurring CR is published four times a year. Codes are updated three times a year, April, July and October as part of this recurring CR. The fourth publication in January is usually used to address MREP enhancement requests.

As mentioned earlier, specific CMS components may publish CRs in addition to the recurring code update CRs instructing contractors to use specific CARCs/ RARCs and establishing an 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 of the two dates (see table under General Information for exceptions).

By April 2, 2012, contractors must complete entry of all applicable code text changes and new codes, and the SSMs shall implement all code deactivations, if any. **(NOTE: Deactivation decisions made earlier may be included in earlier CRs – consult the complete lists posted at WPC Web site. Contractors must use the latest approved and valid Claim Adjustment Reason Codes and Remittance Advice Remark Codes in the 835 and corresponding Standard Paper Remittance (SPR) advice, and the latest approved and valid Claim Adjustment Reason Codes in the 837 COB.)**

NOTE: 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 the word "Alert" in the text to identify them as informational rather than explanatory codes. These "Informational" codes may be used without any specific monetary adjustment and an associated CARC explaining the monetary 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 e.g., 16, 96, 125, 129, 148, 226, 227, 234, A1, and D23.

New Codes – RARC:
None

Modified Codes – RARC:
None

Deactivated Codes – RARC:

None

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. If there is any adjustment, appropriate Group Code must be reported as well. Additionally, for transaction 837 COB, CARC must be used. CARC and RARC code sets are updated three times a year on a regular basis. Medicare contractors must report only currently valid codes in both the remittance advice and COB Claim transaction, and must allow deactivated CARC and RARC in derivative messages when certain conditions are met (see Business Requirements 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 and/or the specific CR that describes the change in policy that resulted in the code change requested by Medicare. Any modification and/or deactivation will be implemented by Medicare even when the modification and/or the deactivation has not been initiated by Medicare.

II. BUSINESS REQUIREMENTS 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	
7683.1	Contractors shall update reason and remark codes that have been modified and apply to Medicare by April 2, 2012. **NOTE: Some modifications may become effective at a future date. Contractors shall make sure that modifications are implemented on the effective date as posted on the WPC Web site (which may be later than the implementation date mentioned in this CR) for those code modifications that are being used by Medicare.**	X	X	X	X	X					
7683.2	Contractors shall update reason and remark codes to include new codes that apply to Medicare by April 2, 2012 or after April 2, 2012 if instructed by CMS. **NOTE: Some new codes may become effective at a future date. Contractors shall make sure that new codes are implemented, if directed by CMS, on the effective date or later as posted on the WPC Web site.**	X	X	X	X	X					
7683.3	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 April 2,						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	
	2012. **NOTE: Check the updated lists as posted on the WPC Web site to capture deactivations that were included in previous CR(s).**										
7683.4	FISS, MCS, and VMS shall make sure that no deactivated code in the attached list of deactivated CARC and RARC codes is being reported on the remittance advice and the 837COB if applicable on or before April 2, 2012. Attachment I for Deactivated List of CARCs Attachment II for Deactivated List of RARCs						X	X	X		
7683.5	FISS, MCS, VMS shall update any crosswalk between the standard reason and remark codes and the shared system internal codes provided to the contractors and make any standard code deactivated since the last update unavailable for use by the contractor by April 2, 2012.						X	X	X		
7683.6	FISS, MCS, CEDI shall make necessary programming changes so that deactivated reason and remark codes are allowed in derivative messages after the deactivation implementation date per this CR or as posted on the WPC Web site when: • Medicare is not primary; • The COB claims 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
7683.7	FISS, MCS, and VMS shall make necessary programming changes so that deactivated reason and remark codes are allowed even after the deactivation implementation 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		
7683.8	VMS shall update the Medicare Remit Easy Print (MREP) software by April 2, 2012. This update shall be based on the CARC and RARC lists as posted on WPC Web site on or around 11-1-2011. **NOTE: This update is provided in a separate file since April, 2008.**								X		
7683.9	FISS shall update the PC Print software by April 2, 2012.						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	
	This update shall be based on the CARC and RARC lists as posted on WPC Web site on or around 11-1-2011.										
7683.10	A/B MACs, carriers, and CEDI for DME MACs shall notify the users that the code update file must be downloaded to be used in conjunction with the updated MREP/PC Print software.	X			X						CEDI

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	
7683.11	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 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					CEDI

IV. SUPPORTING INFORMATION

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

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

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): Contact your Contracting Officer's Technical Representative (COTR) or Contractor Manager, as applicable.

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.

ATTACHMENTS (2)

Attachment I: Claim Adjustment Reason Codes - Deactivated and To Be Deactivated

Attachment II: Remittance Advice Remark Codes - Deactivated and To Be Deactivated

Claim Adjustment Reason Codes - Deactivated and To Be Deactivated

(As of 11/1/2011)

Code	Description
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.)
	Start: 01/01/1995 | Last Modified: 09/21/2008 | Stop: 07/01/2009
25	Payment denied. Your Stop loss deductible has not been met.
	Start: 01/01/1995 | Stop: 04/01/2008
28	Coverage not in effect at the time the service was provided.
	Start: 01/01/1995 | Stop: 10/16/2003
	Notes: Redundant to codes 26&27.
30	Payment adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.
	Start: 01/01/1995 | Stop: 02/01/2006
36	Balance does not exceed co-payment amount.
	Start: 01/01/1995 | Stop: 10/16/2003
37	Balance does not exceed deductible.
	Start: 01/01/1995 | Stop: 10/16/2003
41	Discount agreed to in Preferred Provider contract.
	Start: 01/01/1995 | Stop: 10/16/2003
42	Charges exceed our fee schedule or maximum allowable amount. (Use CARC 45)
	Start: 01/01/1995 | Last Modified: 10/31/2006 | Stop: 06/01/2007
43	Gramm-Rudman reduction.
	Start: 01/01/1995 | Stop: 07/01/2006
46	This (these) service(s) is (are) not covered.

Claim Adjustment Reason Codes - Deactivated and To Be Deactivated	
(As of 11/1/2011)	
Code	Description
	Start: 01/01/1995 | Stop: 10/16/2003
	Notes: Use code 96.
47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.
	Start: 01/01/1995 | Stop: 02/01/2006
48	This (these) procedure(s) is (are) not covered.
	Start: 01/01/1995 | Stop: 10/16/2003
	Notes: Use code 96.
52	The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.
	Start: 01/01/1995 | Stop: 02/01/2006
57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.
	Start: 01/01/1995 | Stop: 06/30/2007
	Notes: Split into codes 150, 151, 152, 153 and 154.
62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.
	Start: 01/01/1995 | Last Modified: 10/31/2006 | Stop: 04/01/2007
63	Correction to a prior claim.
	Start: 01/01/1995 | Stop: 10/16/2003
64	Denial reversed per Medical Review.
	Start: 01/01/1995 | Stop: 10/16/2003
65	Procedure code was incorrect. This payment reflects the correct code.
	Start: 01/01/1995 | Stop: 10/16/2003

Claim Adjustment Reason Codes - Deactivated and To Be Deactivated	
(As of 11/1/2011)	
Code	Description
67	Lifetime reserve days. (Handled in QTY, QTY01=LA)
	Start: 01/01/1995 | Stop: 10/16/2003
68	DRG weight. (Handled in CLP12)
	Start: 01/01/1995 | Stop: 10/16/2003
71	Primary Payer amount.
	Start: 01/01/1995 | Stop: 06/30/2000
	Notes: Use code 23.
72	Coinsurance day. (Handled in QTY, QTY01=CD)
	Start: 01/01/1995 | Stop: 10/16/2003
73	Administrative days.
	Start: 01/01/1995 | Stop: 10/16/2003
77	Covered days. (Handled in QTY, QTY01=CA)
	Start: 01/01/1995 | Stop: 10/16/2003
79	Cost Report days. (Handled in MIA15)
	Start: 01/01/1995 | Stop: 10/16/2003
80	Outlier days. (Handled in QTY, QTY01=OU)
	Start: 01/01/1995 | Stop: 10/16/2003
81	Discharges.
	Start: 01/01/1995 | Stop: 10/16/2003
82	PIP days.

Claim Adjustment Reason Codes - Deactivated and To Be Deactivated	
(As of 11/1/2011)	
Code	Description
	Start: 01/01/1995 | Stop: 10/16/2003
83	Total visits.
	Start: 01/01/1995 | Stop: 10/16/2003
84	Capital Adjustment. (Handled in MIA)
	Start: 01/01/1995 | Stop: 10/16/2003
86	Statutory Adjustment.
	Start: 01/01/1995 | Stop: 10/16/2003
	Notes: Duplicative of code 45.
88	Adjustment amount represents collection against receivable created in prior overpayment.
	Start: 01/01/1995 | Stop: 06/30/2007
92	Claim Paid in full.
	Start: 01/01/1995 | Stop: 10/16/2003
93	No Claim level Adjustments.
	Start: 01/01/1995 | Stop: 10/16/2003
	Notes: As of 004010, CAS at the claim level is optional.
98	The hospital must file the Medicare claim for this inpatient non-physician service.
	Start: 01/01/1995 | Stop: 10/16/2003
99	Medicare Secondary Payer Adjustment Amount.
	Start: 01/01/1995 | Stop: 10/16/2003
113	Payment denied because service/procedure was provided outside the United States or as a result of war.

Claim Adjustment Reason Codes - Deactivated and To Be Deactivated	
(As of 11/1/2011)	
Code	Description
	Start: 01/01/1995 | Last Modified: 02/28/2001 | Stop: 06/30/2007
	Notes: Use Codes 157, 158 or 159.
120	Patient is covered by a managed care plan.
	Start: 01/01/1995 | Stop: 06/30/2007
	Notes: Use code 24.
123	Payer refund due to overpayment.
	Start: 01/01/1995 | Stop: 06/30/2007
	Notes: Refer to implementation guide for proper handling of reversals.
124	Payer refund amount - not our patient.
	Start: 01/01/1995 | Last Modified: 06/30/1999 | Stop: 06/30/2007
	Notes: Refer to implementation guide for proper handling of reversals.
126	Deductible -- Major Medical
	Start: 02/28/1997 | Last Modified: 09/30/2007 | Stop: 04/01/2008
	Notes: Use Group Code PR and code 1.
127	Coinsurance -- Major Medical
	Start: 02/28/1997 | Last Modified: 09/30/2007 | Stop: 04/01/2008
	Notes: Use Group Code PR and code 2.
145	Premium payment withholding
	Start: 06/30/2002 | Last Modified: 09/30/2007 | Stop: 04/01/2008
	Notes: Use Group Code CO and code 45.

Claim Adjustment Reason Codes - Deactivated and To Be Deactivated	
(As of 11/1/2011)	
Code	Description
156	Flexible spending account payments. Note: Use code 187.
	Start: 09/30/2003 | Last Modified: 01/25/2009 | Stop: 10/01/2009
196	Claim/service denied based on prior payer's coverage determination.
	Start: 06/30/2006 | Stop: 02/01/2007
	Notes: Use code 136.
A2	Contractual adjustment.
	Start: 01/01/1995 | Last Modified: 02/28/2007 | Stop: 01/01/2008
	Notes: Use Code 45 with Group Code 'CO' or use another appropriate specific adjustment code.
A3	Medicare Secondary Payer liability met.
	Start: 01/01/1995 | Stop: 10/16/2003
A4	Medicare Claim PPS Capital Day Outlier Amount.
	Start: 01/01/1995 | Last Modified: 09/30/2007 | Stop: 04/01/2008
B2	Covered visits.
	Start: 01/01/1995 | Stop: 10/16/2003
B3	Covered charges.
	Start: 01/01/1995 | Stop: 10/16/2003
B6	This payment is adjusted when performed/billed by this type of provider, by this type of provider in this type of facility, or by a provider of this specialty.
	Start: 01/01/1995 | Stop: 02/01/2006
B17	Payment adjusted because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current.
	Start: 01/01/1995 | Stop: 02/01/2006

Claim Adjustment Reason Codes - Deactivated and To Be Deactivated	
(As of 11/1/2011)	
Code	Description
B18	This procedure code and modifier were invalid on the date of service.
	Start: 01/01/1995 | Last Modified: 09/21/2008 | Stop: 03/01/2009
B19	Claim/service adjusted because of the finding of a Review Organization.
	Start: 01/01/1995 | Stop: 10/16/2003
B21	The charges were reduced because the service/care was partially furnished by another physician.
	Start: 01/01/1995 | Stop: 10/16/2003
D1	Claim/service denied. Level of subluxation is missing or inadequate.
	Start: 01/01/1995 | Stop: 10/16/2003
	Notes: Use code 16 and remark codes if necessary.
D2	Claim lacks the name, strength, or dosage of the drug furnished.
	Start: 01/01/1995 | Stop: 10/16/2003
	Notes: Use code 16 and remark codes if necessary.
D3	Claim/service denied because information to indicate if the patient owns the equipment that requires the part or supply was missing.
	Start: 01/01/1995 | Stop: 10/16/2003
	Notes: Use code 16 and remark codes if necessary.
D4	Claim/service does not indicate the period of time for which this will be needed.
	Start: 01/01/1995 | Stop: 10/16/2003
	Notes: Use code 16 and remark codes if necessary.
D5	Claim/service denied. Claim lacks individual lab codes included in the test.
	Start: 01/01/1995 | Stop: 10/16/2003

Claim Adjustment Reason Codes - Deactivated and To Be Deactivated	
(As of 11/1/2011)	
Code	Description
	Notes: Use code 16 and remark codes if necessary.
D6	Claim/service denied. Claim did not include patient's medical record for the service.
	Start: 01/01/1995 | Stop: 10/16/2003
	Notes: Use code 16 and remark codes if necessary.
D7	Claim/service denied. Claim lacks date of patient's most recent physician visit.
	Start: 01/01/1995 | Stop: 10/16/2003
	Notes: Use code 16 and remark codes if necessary.
D8	Claim/service denied. Claim lacks indicator that 'x-ray is available for review.'
	Start: 01/01/1995 | Stop: 10/16/2003
	Notes: Use code 16 and remark codes if necessary.
D9	Claim/service denied. Claim lacks invoice or statement certifying the actual cost of the lens, less discounts or the type of intraocular lens used.
	Start: 01/01/1995 | Stop: 10/16/2003
	Notes: Use code 16 and remark codes if necessary.
D10	Claim/service denied. Completed physician financial relationship form not on file.
	Start: 01/01/1995 | Stop: 10/16/2003
	Notes: Use code 17.
D11	Claim lacks completed pacemaker registration form.
	Start: 01/01/1995 | Stop: 10/16/2003
	Notes: Use code 17.
D12	Claim/service denied. Claim does not identify who performed the purchased diagnostic test or the amount you were charged for the test.

Claim Adjustment Reason Codes - Deactivated and To Be Deactivated	
(As of 11/1/2011)	
Code	Description
	Start: 01/01/1995 | Stop: 10/16/2003
	Notes: Use code 17.
D13	Claim/service denied. Performed by a facility/supplier in which the ordering/referring physician has a financial interest.
	Start: 01/01/1995 | Stop: 10/16/2003
	Notes: Use code 17.
D14	Claim lacks indication that plan of treatment is on file.
	Start: 01/01/1995 | Stop: 10/16/2003
	Notes: Use code 17.
D15	Claim lacks indication that service was supervised or evaluated by a physician.
	Start: 01/01/1995 | Stop: 10/16/2003
	Notes: Use code 17.
D16	Claim lacks prior payer payment information.
	Start: 01/01/1995 | Stop: 06/30/2007
	Notes: Use code 16 with appropriate claim payment remark code [N4].
D17	Claim/Service has invalid non-covered days.
	Start: 01/01/1995 | Stop: 06/30/2007
	Notes: Use code 16 with appropriate claim payment remark code.
D18	Claim/Service has missing diagnosis information.
	Start: 01/01/1995 | Stop: 06/30/2007
	Notes: Use code 16 with appropriate claim payment remark code.

Claim Adjustment Reason Codes - Deactivated and To Be Deactivated	
(As of 11/1/2011)	
Code	Description
D19	Claim/Service lacks Physician/Operative or other supporting documentation
	Start: 01/01/1995 | Stop: 06/30/2007
	Notes: Use code 16 with appropriate claim payment remark code.
D20	Claim/Service missing service/product information.
	Start: 01/01/1995 | Stop: 06/30/2007
	Notes: Use code 16 with appropriate claim payment remark code.
D21	This (these) diagnosis(es) is (are) missing or are invalid
	Start: 01/01/1995 | Stop: 06/30/2007
D22	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
TO BE DEACTIVATED	
87	Transfer amount. *Start: 01/01/1995 | Last Modified: 09/20/2009 | Stop: 01/01/2012*
141	Claim spans eligible and ineligible periods of coverage. *Start: 06/30/1999 | Last Modified: 09/30/2007 | Stop: 07/01/2012*
D23	This dual eligible patient is covered by Medicare Part D per Medicare Retro-Eligibility. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) *Start: 11/01/2009 | Stop: 01/01/2012*

Attachment II

For Alternate format, please contact the CR author

Remittance Advice Remark Codes - Deactivated and To Be Deactivated (As of

Code	Description	Effective Date	Deactivation Date	Last Modified Date	Notes
M72	Did not enter full 8-digit date (MM/DD/CCYY).	01/01/1997	10/16/2003		Consider using MA52
MA05	Incorrect admission date patient status or type of bill entry on claim.	01/01/1997	10/16/2003		Consider using MA30, MA40 or MA43
MA98	Claim Rejected. Does not contain the correct Medicare Managed Care Demonstration contract number for this beneficiary.	01/01/1997	10/16/2003		Consider using MA97
N41	Authorization request denied.	01/01/2000	10/16/2003		Consider using Reason Code 39
N44	Payer's share of regulatory surcharges, assessments, allowances or health care-related taxes paid directly to the regulatory authority.	01/01/2000	10/16/2003		Consider using Reason Code 137
MA95	A not otherwise classified or unlisted procedure code(s) was billed but a narrative description of the procedure was not entered on the claim. Refer to item 19 on the HCFA-1500.	01/01/1997	01/01/2004	02/28/2003	(Deactivated 2/28/2003) (Erroneous description corrected 9/2/2008) Consider using M51
M140	Service not covered until after the patient's 50th birthday, i.e., no coverage prior to the day after the 50th birthday	01/01/1997	01/30/2004		Consider using M82
M43	Payment for this service previously issued to you or another provider by another carrier/intermediary.	01/01/1997	01/31/2004		Consider using Reason Code 23
M48	Payment for services furnished to hospital inpatients (other than professional services of physicians) can only be made to the hospital. You must request payment from the hospital rather than the patient for this service.	01/01/1997	01/31/2004		Consider using M97
M63	We do not pay for more than one of these on the same day.	01/01/1997	01/31/2004		Consider using M86
M98	Begin to report the Universal Product Number on claims for items of this type. We will soon begin to deny payment for items of this type if billed without the correct UPN.	01/01/1997	01/31/2004		Consider using M99
M101	Begin to report a G1-G5 modifier with this HCPCS. We will soon begin to deny payment for this service if billed without a G1-G5 modifier.	01/01/1997	01/31/2004		Consider using M78
M106	Information supplied does not support a break in therapy. A new capped rental period will not begin. This is the maximum approved under the fee schedule for this item or service.	01/01/1997	01/31/2004		Consider using MA 31

MA11	Payment is being issued on a conditional basis. If no-fault insurance, liability insurance, Workers' Compensation, Department of Veterans Affairs, or a group health plan for employees and dependents also covers this claim, a refund may be due us. Please contact us if the patient is covered by any of these sources.	01/01/1997	01/31/2004		Consider using M32
MA78	The patient overpaid you. You must issue the patient a refund within 30 days for the difference between our allowed amount total and the amount paid by the patient.	01/01/1997	01/31/2004		Consider using MA59
MA104	Missing/incomplete/invalid date the patient was last seen or the provider identifier of the attending physician.	01/01/1997	01/31/2004		Consider using M128 or M57
MA124	Processed for IME only.	01/01/1997	01/31/2004		Consider using Reason Code 74
MA129	This provider was not certified for this procedure on this date of service.	10/12/2001	01/31/2004	01/31/2004	Consider using MA120 and Reason Code B7
N18	Payment based on the Medicare allowed amount.	01/01/2000	01/31/2004		Consider using N14
N60	A valid NDC is required for payment of drug claims effective October 02.	01/01/2000	01/31/2004		Consider using M119
N73	A Skilled Nursing Facility is responsible for payment of outside providers who furnish these services/supplies under arrangement to its residents.	01/01/2000	01/31/2004		Consider using MA101 or N200
N101	Additional information is needed in order to process this claim. Please resubmit the claim with the identification number of the provider where this service took place. The Medicare number of the site of service provider should be preceded with the letters 'HSP' and entered into item #32 on the claim form. You may bill only one site of service provider number per claim.	10/31/2001	01/31/2004		Consider uisng MA105
N164	Transportation to/from this destination is not covered.	02/28/2003	01/31/2004		Consider using N157
N165	Transportation in a vehicle other than an ambulance is not covered.	02/28/2003	01/31/2004		Consider using N158)
N166	Payment denied/reduced because mileage is not covered when the patient is not in the ambulance.	02/28/2003	01/31/2004		Consider using N159
N168	The patient must choose an option before a payment can be made for this procedure/ equipment/ supply/ service.	02/28/2003	01/31/2004		Consider using N160
N169	This drug/service/supply is covered only when the associated service is covered.	02/28/2003	01/31/2004		Consider using N161
M33	Missing/incomplete/invalid UPIN for the ordering/referring/performing provider.	01/01/1997	08/01/2004		Consider using M68
M34	Claim lacks the CLIA certification number.	01/01/1997	08/01/2004		Consider using MA120
M88	We cannot pay for laboratory tests unless billed by the laboratory that did the work.	01/01/1997	08/01/2004		Consider using Reason Code B20

M92	Services subjected to review under the Home Health Medical Review Initiative.	01/01/1997	08/01/2004		
MA06	Missing/incomplete/invalid beginning and/or ending date(s).	01/01/1997	08/01/2004		Consider using MA31
MA49	Missing/incomplete/invalid six-digit provider identifier for home health agency or hospice for physician(s) performing care plan oversight services.	01/01/1997	08/01/2004		Consider using MA76
MA85	Our records indicate that a primary payer exists (other than ourselves); however, you did not complete or enter accurately the insurance plan/group/program name or identification number. Enter the PlanID when effective.	01/01/1997	08/01/2004		Consider using MA92
MA86	Missing/incomplete/invalid group or policy number of the insured for the primary coverage.	01/01/1997	08/01/2004		Consider using MA92
MA87	Missing/incomplete/invalid insured's name for the primary payer.	01/01/1997	08/01/2004		Consider using MA92
MA102	Missing/incomplete/invalid name or provider identifier for the rendering/referring/ ordering/ supervising provider.	01/01/1997	08/01/2004		Consider using M68
N17	Per admission deductible.	01/01/2000	08/01/2004		Consider using Reason Code 1
M35	Missing/incomplete/invalid pre-operative photos or visual field results.	01/01/1997	02/05/2005		Consider using N178
M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.	01/01/1997	02/05/2005		
MA51	Missing/incomplete/invalid CLIA certification number for laboratory services billed by physician office laboratory.	01/01/1997	02/05/2005		Consider using MA120
N38	Missing/incomplete/invalid place of service.	01/01/2000	02/05/2005		Consider using M77
N66	Missing/incomplete/invalid documentation.	01/01/2000	02/05/2005		Consider using N29 or N225.
M57	Missing/incomplete/invalid provider identifier.	01/01/1997	06/02/2005		
M68	Missing/incomplete/invalid attending, ordering, rendering, supervising or referring physician identification.	01/01/1997	06/02/2005		
M108	Missing/incomplete/invalid provider identifier for the provider who interpreted the diagnostic test.	01/01/1997	06/02/2005		
M110	Missing/incomplete/invalid provider identifier for the provider from whom you purchased interpretation services.	01/01/1997	06/02/2005		
M120	Missing/incomplete/invalid provider identifier for the substituting physician who furnished the service(s) under a reciprocal billing or locum tenens arrangement.	01/01/1997	06/02/2005		
M128	Missing/incomplete/invalid date of the patient’s last physician visit.	01/01/1997	06/02/2005		
MA29	Missing/incomplete/invalid provider name, city, state, or zip code.	01/01/1997	06/02/2005		
MA38	Missing/incomplete/invalid birth date.	01/01/1997	06/02/2005		

MA52	Missing/incomplete/invalid date.	01/01/1997	06/02/2005		
MA82	Missing/incomplete/invalid provider/supplier billing number/identifier or billing name, address, city, state, zip code, or phone number.	01/01/1997	06/02/2005		
MA105	Missing/incomplete/invalid provider number for this place of service.	01/01/1997	06/02/2005		
MA127	Reserved for future use.	10/12/2001	06/02/2005		
N145	Missing/incomplete/invalid provider identifier for this place of service.	10/31/2002	06/02/2005		
M78	Missing/incomplete/invalid HCPCS modifier.	01/01/1997	05/18/2006	02/28/2003	(Modified 2/28/03,) Consider using Reason Code 4
MA03	If you do not agree with the approved amounts and $100 or more is in dispute (less deductible and coinsurance), you may ask for a hearing within six months of the date of this notice. To meet the $100, you may combine amounts on other claims that have been denied, including reopened appeals if you received a revised decision. You must appeal each claim on time.	01/01/1997	10/01/2006	11/18/2005	Consider using MA02 (Modified 10/31/02, 6/30/03, 8/1/05, 11/18/05)
N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.	01/01/2000	10/01/2007		Consider using Reason Code 45
N361	Payment adjusted based on multiple diagnostic imaging procedure rules	11/18/2005	10/01/2007	12/01/2006	(Modified 12/1/06) Consider using Reason Code 59
MA119	Provider level adjustment for late claim filing applies to this claim.	01/01/1997	05/01/2008	11/05/2007	Consider using Reason Code B4
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.)	08/01/2007	02/01/2009		
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.)	08/01/2007	02/01/2009		
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.)	08/01/2007	02/01/2009		
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.)	08/01/2007	02/01/2009		
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.)	08/01/2007	02/01/2009		

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.)	08/01/2007	02/01/2009		
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.)	08/01/2007	02/01/2009		
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)	11/01/2008	10/01/2009		
M118	Letter to follow containing further information.	01/01/1997	01/01/2011	11/01/2009	Consider using N202
MA101	A Skilled Nursing Facility (SNF) is responsible for payment of outside providers who furnish these services/supplies to residents.	01/01/1997	01/01/2011	06/30/2003	Consider using N538
N201	A mental health facility is responsible for payment of outside providers who furnish these services/supplies to residents.	02/25/2003	01/01/2011		Consider using N538
N514	Consult plan benefit documents/guidelines for information about restrictions for this service.	11/01/2008	01/01/2011		Consider using N130