CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 3298	**Date: August 06, 2015**
	Change Request 9278

This instruction is being re-issued to update attachment II that were previously included. This instruction has been revised. The Transmittal Number, Date Issued and all other information remains the same.

SUBJECT: Remittance Advice Remark and Claims Adjustment Reason Code and Medicare Remit Easy Print and PC Print Update

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update the Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) lists and also instructs ViPS Medicare System (VMS) and Fiscal Intermediary Shared System (FISS) to update Medicare Remit Easy Print (MREP) and PC Print.

EFFECTIVE DATE: October 1, 2015
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 5, 2015

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	N/A

III. FUNDING:
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

Attachment - Recurring Update Notification

Pub. 100-04	Transmittal: 3298	Date: August 06, 2015	Change Request: 9278

SUBJECT: Remittance Advice Remark and Claims Adjustment Reason Code and Medicare Remit Easy Print and PC Print Update

EFFECTIVE DATE: October 1, 2015
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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 CARCs and appropriate 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 and coordination of benefits transactions.

The CARC and RARC changes that impact Medicare are usually requested by the Centers for Medicare and Medicaid Services (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 Washington Publishing Company (WPC) Web site.** 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.

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 9125, issued on April 13, 2015), and does not provide a complete list of codes for these two code sets. The MACs and the SSMs 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. The implementation date for any new or modified or deactivated code for Medicare contractors is established by this recurring code update CR published three times a year according to the Medicare release schedule and/or specific CR from a CMS component implementing a policy change that impacts Remittance Advice code use.

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

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

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 or deactivation becomes effective at a future date, contractors must make sure that they update on the effective date or the quarterly release date that matches the effective date

as posted on the WPC Web site.

B. Policy: In accordance with the Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) Phase III Operating Rules, the 835 transaction (Health Care Claim Payment/Advice) and standard paper remittance advice, require the use of two code sets – CARCs and RARCs – that are required to be used along with Group Codes to report payment adjustments, Informational RARCs to report appeal rights, and other adjudication related information. Additionally, transaction 837 COB requires the use of CARCs and RARCs. Entities are required to report only currently valid codes in both the remittance advice and COB Claim transaction, and must allow deactivated CARCs and RARCs in derivative messages when specific criteria are met (see Business Requirements segment for explanation of conditions).

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
9278.1	Contractors shall update reason and remark codes that have been modified and apply to Medicare by October 05, 2015, per Attachment I and Attachment II for CARC and RARC changes respectively. **NOTE:** Some modifications may become effective at a future date. Contractors shall make sure that modifications are implemented **on the effective date** (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					
9278.2	Contractors shall update reason and remark codes to include new codes that apply to Medicare by October 05, 2015, if and as instructed by CMS. See Attachment I and II for CARC and RARC changes respectively since CR 9125. 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 as posted on the WPC website or later as directed	X	X	X	X					

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
9278.3	Contractors 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 October 05, 2015. NOTE: Check the updated lists as posted on the WPC Web site to capture deactivations that were included in previous CR(s).		X			X	X			
9278.4	FISS and Multi-Carrier System (MCS) 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 October 05, 2015.					X	X			
9278.5	Contractors 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 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
9278.6	Contractors 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		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	situation, when a value of 22 in CLP02 identifies the claim to be a corrected claim, and in Medicare Secondary Payer (MSP) claims, when forwarded to Medicare by primary payers before the deactivation date and Medicare adjudication is done after deactivation date.									
9278.7	VMS shall update the Medicare Remit Easy Print (MREP) software by October 05, 2015. This update shall be based on the CARC and RARC lists as posted on WPC Web site on July 1, 2015.							X		
9278.8	FISS shall update the PC Print software by October 05, 2015. This update shall be based on the CARC and RARC lists as posted on WPC Web site on July 1, 2015.					X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
9278.9	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/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 sites and include information about it in a listserv message within 5 business days after receipt of the notification from CMS announcing the availability of the article. In addition, the provider education article shall be included in the contractor's 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	X	X	X	X	X

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	Medicare program correctly.					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Sheena Pierce, 410-786-3449 or sheena.pierce@cms.hhs.gov , Lauren Vandegrift, 410-786-4882 or lauren.vandegrift@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: 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

CR

ATTACHMENT I: Changes in CARC List since CR 9125

New Codes – CARC:

Code	Modified Narrative	Effective Date
270	Claim received by the medical plan, but benefits not available under this plan. Submit these services to the patient's dental plan for further consideration.	07/01/2015

Modified Codes – CARC:

Code	Modified Narrative	Effective Date
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Note: this must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability)	11/01/2015

Deactivated Codes – CARC

Code	Current Narrative	Effective Date

These are changes in the CARC database since the last code update CR 9125. The full CARC list must be downloaded from the WPC website:
http://wpc-edi.com/Reference/

CR

ATTACHMENT II: Changes in RARC List since CR 9125

New Codes – RARC:

Code	Modified Narrative	Effective Date
N753	Missing/incomplete/invalid Attachment Control Number.	07/01/2015
N754	Missing/Incomplete/Invalid Referring Provider or Other Source Qualifier on the 1500 Claim Form.	07/01/2015
N755	Missing/Incomplete/Invalid ICD Indicator on the 1500 Claim Form.	07/01/2015
N756	Missing/incomplete/invalid point of drop-off address.	07/01/2015
N757	Adjusted based on the Federal Indian Fees schedule (MLR).	07/01/2015
N758	Adjusted based on the prior authorization decision.	07/01/2015
N759	Payment adjusted based on the National Electrical Manufacturers Association (NEMA) Standard XR-29-2013.	07/01/2015

Modified Codes – RARC:

Code	Modified Narrative	Effective Date
M47	Missing/incomplete/invalid Payer Claim Control Number. Other terms exist for this element including, but not limited to, Internal Control Number (ICN), Claim Control Number (CCN), Document Control Number (DCN).	07/01/2015
MA74	Alert: This payment replaces an earlier payment for this claim that was either lost, damaged or returned.	07/01/2015
N432	ALERT: Adjustment based on a Recovery Audit.	07/01/2015
N22	ALERT: This procedure code was added/changed because it more accurately describes the services rendered.	07/01/2015
M39	ALERT: The patient is not liable for payment of this service as the advance notice of non-coverage you provided the patient did not comply with program requirements.	07/01/2015
N109	Alert: This claim/service was chosen for complex review.	07/01/2015
M38	ALERT: The patient is liable for the charges for this service as they were informed in writing before the service was furnished that we would not pay for it and the patient agreed to be responsible for the charges.	07/01/2015
N381	ALERT: Consult our contractual agreement for restrictions/billing/payment information related to these charges.	07/01/2015

MA91	ALERT: This determination is the result of the appeal you filed.	07/01/2015

Deactivated Codes – RARC

Code	Current Narrative	Effective Date
N102	This claim has been denied without reviewing the medical/dental record because the requested records were not received or were not received timely.	07/01/2016

N735- This RARC is not included in the list of deactivated codes because CMS did not add this code during the previous release when it was included on the WPC website. The RARC was previously added to the WPC website erroneously.

These are changes in the RARC database since the last code update CR 9125. The full RARC list must be downloaded from the WPC website:
http://wpc-edi.com/Reference/