DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

The Centers for Medicare & Medicaid Services (CMS) is launching a new instrument for 2013 called the MAC Satisfaction Indicator (MSI). The MSI is a tool that measures providers' satisfaction with their Medicare claims administrative contractor(s). Your input will help your MAC to improve the services that they offer you. Participation is voluntary, but you must register to participate. Complete the application at https://adobeformscentral.com/?f=eMRKPqaWpqMxNOmTQpSKDA on the Internet. For more information, visit http://www.cms.gov/Medicare/Medicare-Contracting/MSI on the CMS website.

MLN Matters® Number: MM8422

Related Change Request (CR) #: CR 8422

Related CR Release Date: August 30, 2013

Effective Date: October 1, 2013

Related CR Transmittal #: R2776CP

Implementation Date: October 7, 2013

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

Provider Types Affected

This MLN Matters® Article is intended is intended for physicians, providers, and suppliers submitting claims to Medicare contractors (Fiscal Intermediaries (FI), Regional Home Health Intermediaries (RHHI), carriers, Durable Medical Equipment Medicare Administrative Contractors (DME MAC) and Medicare Administrative Contractors (A/B MAC) for services to Medicare beneficiaries.

What You Need To Know

CR 8422, from which this article is taken, updates the Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) lists, effective October 1, 2013; and also instructs the Fiscal Intermediary Standard System (FISS) and VIPs Medicare System (VMS) maintainers to update Medicare Remit Easy Print (MREP) and PC Print. You should make sure that your billing staffs are aware of these updates.

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. Accordingly, Medicare policy states that two standard code sets (Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC)) must be used for:

- Transaction 835 (Health Care Claim Payment/Advice) and standard paper remittance advice, (along with Group Code) to report payment adjustments; and Informational RARCs to report appeal rights, and other adjudication related information; and
- Transaction 837 (coordination of benefits (COB)).

Staff at the Centers for Medicare & Medicaid Services (CMS) usually request the CARC and RARC changes that impact Medicare, in conjunction with a policy change. If an entity other than CMS initiates a modification for a code that Medicare currently uses, 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.

CARC and RARC code sets are regularly updated three times a year. CR 8422 lists only the changes that have been approved since the last code update CR (CR 8281, Transmittal 262686, issued on April 12, 2013), and does not provide a complete list of codes for these two code sets.

Note: In case of any discrepancy in the code text as posted on Washington Publishing Company (WPC) website and as reported in any CR, the WPC version should be implemented.

Changes in CARC List Since CR8281

These are the changes in the CARC database since the last code update CR8281. The full CARC list may be downloaded from the WPC website, available at http://wpc-edi.com/Reference on the Internet.

New Codes – CARC:

Code	Narrative	Effective Date
253	Sequestration - reduction in federal spending.	06/02/2013
254	Claim received by the dental plan, but benefits not available under this plan. Submit these services to the patient's medical plan for further consideration.	06/02/2013
255	The disposition of the related Property & Casualty claim (injury or illness) is pending due to litigation. (Use only with Group Code OA)	06/02/2013
256	Service not payable per managed care contract.	06/02/2013

W5	Medical provider not authorized/certified to provide treatment to injured workers in this jurisdiction. (Use with Group Code CO or OA)	06/02/2013
W6	Referral not authorized by attending physician per regulatory requirement.	06/02/2013
W7	Procedure is not listed in the jurisdiction fee schedule. An allowance has been made for a comparable service.	06/02/2013
W8	Procedure has a relative value of zero in the jurisdiction fee schedule, therefore no payment is due.	06/02/2013
W9	Service not paid under jurisdiction allowed outpatient facility fee schedule.	06/02/2013

Modified Codes – CARC:

Code	Modified Narrative	Effective Date
16	Claim/service lacks information which is needed for adjudication. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. 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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	06/02/2013
18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	06/02/2013
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability)	07/01/2013
136	Failure to follow prior payer's coverage rules. (Use only with Group Code OA)	07/01/2013
163	Attachment/other documentation referenced on the claim was not received.	06/02/2013
164	Attachment/other documentation referenced on the claim was not received in a timely fashion.	06/02/2013
173	Service/equipment was not prescribed by a physician.	07/01/2013

Code	Modified Narrative	Effective Date
201	Workers' Compensation case settled. Patient is responsible for amount of this claim/service through WC 'Medicare set aside arrangement' or other agreement. (Use only with Group Code PR)	07/01/2013
209	Per regulatory or other agreement. The provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to patient if collected. (Use only with Group code OA)	07/01/2013
221	Claim is under investigation. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). (Note: To be used by Property & Casualty only)	07/01/2013
226	Information requested from the Billing/Rendering Provider was not provided or not provided timely or was insufficient/incomplete. 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.)	07/01/2013
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 only with Group Code PR)	07/01/2013
236	This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/ fee schedule requirements.	07/01/2013
238	Claim spans eligible and ineligible periods of coverage, this is the reduction for the ineligible period. (Use only with Group Code PR)	07/01/2013
242	Services not provided by network/primary care providers *Notes: This code replaces deactivated code 38*	06/02/2013
243	Services not authorized by network/primary care providers. *Notes: This code replaces deactivated code 38*	06/02/2013
250	The attachment/other documentation content received is	06/02/2013

Code	Modified Narrative	Effective Date
	inconsistent with the expected content.	
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	06/02/2013
252	An attachment/other documentation is required to adjudicate this claim/service. 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).	06/02/2013
W1	Workers' compensation jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply.	06/02/2013
W2	Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies, use only if no other code is applicable. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (Loop 2110 Service Payment information REF) if the regulations apply. To be used for Workers' Compensation only.	06/02/2013
Y1	Payment denied based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional regulations or payment policies, use only if no other code is applicable. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (Loop 2110 Service Payment information REF) if the regulations apply. To be used for P&C Auto only.	06/02/2013
Y2	Payment adjusted based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional	06/02/2013

Code	Modified Narrative	Effective Date
	regulations or payment policies, use only if no other code is applicable. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (Loop 2110 Service Payment information REF) if the regulations apply. To be used for P&C Auto only.	
Y3	Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (Loop 2110 Service Payment information REF) if the regulations apply. To be used for P&C Auto only.	06/02/2013

Deactivated Codes (Also included in CR 8281) – CARC

Code	Current Narrative	Effective Date
125	Submission/billing error(s). 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.)	11/01/2013

Changes in RARC List Since CR8281

These are the changes in the RARC database since the last code update CR8281. The full RARC list may be downloaded from the WPC website, available at http://wpc-edi.com/Reference on the internet.

New Codes– RARC:

Code	Current Narrative	Effective Date
N574	Our records indicate the ordering/referring provider is of a type/specialty that cannot order or refer. Please verify that the claim ordering/referring provider information is accurate or contact the ordering/referring provider.	07/15/2013
N575	Mismatch between the submitted ordering/referring provider name and the ordering/referring provider name stored in our records.	07/15/2013
N576	Services not related to the specific incident/claim/accident/loss being reported.	07/15/2013

Code	Current Narrative	Effective Date
N577	Personal Injury Protection (PIP) Coverage.	07/15/2013
N578	Coverages do not apply to this loss.	07/15/2013
N579	Medical Payments Coverage (MPC).	07/15/2013
N580	Determination based on the provisions of the insurance policy.	07/15/2013
N581	Investigation of coverage eligibilty is pending.	07/15/2013
N582	Benefits suspended pending the patient's cooperation.	07/15/2013
N583	Patient was not an occupant of our insured vehicle and therefore, is not an eligible injured person.	07/15/2013
N584	Not covered based on the insured's noncompliance with policy or statutory conditions.	07/15/2013
N585	Benefits are no longer available based on a final injury settlement.	07/15/2013
N586	The injured party does not qualify for benefits.	07/15/2013
N587	Policy benefits have been exhausted.	07/15/2013
N588	The patient has instructed that medical claims/bills are not to be paid.	07/15/2013
N589	Coverage is excluded to any person injured as a result of operating a motor vehicle while in an intoxicated condition or while the ability to operate such a vehicle is impaired by the use of a drug.	07/15/2013
N590	Missing independent medical exam detailing the cause of injuries sustained and medical necessity of services rendered.	07/15/2013
N591	Payment based on an Independent Medical Examination (IME) or Utilization Review (UR).	07/15/2013
N592	Adjusted because this is not the initial prescription oe exceeds the amount allowed for the initial prescription.	07/15/2013
N593	Not covered based on failure to attend a scheduled Independent Medical Exam (IME).	07/15/2013
N594	Records reflect the injured party did not complete an Application for Benefits for this loss.	07/15/2013
N595	Records reflect the injured party did not complete an Assignment of Benefits for this loss.	07/15/2013
N596	Records reflect the injured party did not complete a Medical Authorization for this loss.	07/15/2013
N597	Adjusted based on a medical provider's apportionment of care between related injuries and other unrelated medical	07/15/2013

Code	Current Narrative	Effective Date
	conditions/injuries.	
N598	Health care policy coverage is primary.	07/15/2013
N599	Our payment for this service is based upon a reasonable amount pursuant to both the terms and conditions of the policy of insurance under which the subject claim is being made as well as the Florida No-Fault Statute, which permits, when determining a reasonable charge for a service, an insurer to consider usual and customary charges and payments accepted by the provider, reimbursement levels in the community and various federal and state fee schedules applicable to automobile and other insurance coverages, and other information relevant to the reasonableness of the reimbursement for the service. The payment for this service is based upon 200% of the Participating Level of Medicare Part B fee schedule for the locale in which the services were rendered.	07/15/2013
N600	Adjusted based on the applicable fee schedule for the region in which the service was rendered.	07/15/2013
N601	In accordance with Hawaii Administrative Rules, Title 16, Chapter 23 Motor Vehicle Insurance Law payment is recommended based on Medicare Resource Based Relative Value Scale System applicable to Hawaii.	07/15/2013
N602	Adjusted based on the Redbook maximum allowance.	07/15/2013
N603	This fee is calculated according to the New Jersey medical fee schedules for Automobile Personal Injury Protection and Motor Bus Medical Expense Insurance Coverage.	07/15/2013
N604	In accordance with New York No-Fault Law, Regulation 68, this base fee was calculated according to the New York Workers' Compensation Board Schedule of Medical Fees, pursuant to Regulation 83 and / or Appendix 17-C of 11 NYCRR.	07/15/2013
N605	This fee was calculated based upon New York All Patients Refined Diagnosis Related Groups (APR-DRG), pursuant to Regulation 68.	07/15/2013
N606	The Oregon allowed amount for this procedure is based upon the Workers Compensation Fee Schedule (OAR 436-009). The allowed amount has been calculated in accordance with Section 4 of ORS 742.524.	07/15/2013
N607	Service provided for non-compensable condition(s).	07/15/2013
N608	The fee schedule amount allowed is calculated at 110% of the Medicare Fee Schedule for this region, specialty and type of service. This fee is calculated in compliance with Act 6.	07/15/2013

Code	Current Narrative	Effective Date
N609	80% of the providers billed amount is being recommended for payment according to Act 6.	07/15/2013
N610	Alert: Payment based on an appropriate level of care.	07/15/2013
N611	Claim in litigation. Contact insurer for more information.	07/15/2013
N612	Medical provider not authorized/certified to provide treatment to injured workers in this jurisdiction.	07/15/2013
N613	Alert: Although this was paid, you have billed with an ordering provider that needs to update their enrollment record. Please verify that the ordering provider information you submitted on the claim is accurate and if it is, contact the ordering provider instructing them to update their enrollment record. Unless corrected, a claim with this ordering provider will not be paid in the future.	07/15/2013
N614	Alert: Additional information is included in the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information).	07/15/2013
N615	Alert: This enrollee receiving advance payments of the premium tax credit is in the grace period of three consecutive months for non-payment of premium. Under the Code of Federal Regulations, Title 45, Part 156.270, a Qualified Health Plan issuer must pay all appropriate claims for services rendered to the enrollee during the first month of the grace period and may pend claims for services rendered to the enrollee in the second and third months of the grace period.	07/15/2013
N616	Alert: This enrollee is in the first month of the advance premium tax credit grace period.	07/15/2013
N617	This enrollee is in the second or third month of the advance premium tax credit grace period.	07/15/2013
N618	Alert: This claim will automatically be reprocessed if the enrollee pays their premiums.	07/15/2013
N619	Coverage terminated for non-payment of premium.	07/15/2013
N620	Alert: This procedure code is for quality reporting/informational purposes only.	07/15/2013
N621	Charges for Jurisdiction required forms, reports, or chart notes are not payable.	07/15/2013
N622	Not covered based on the date of injury/accident.	07/15/2013

Code	Current Narrative	Effective Date
N623	Not covered when deemed unscientific/unproven/outmoded/experimental/excessive/inappropriate.	07/15/2013
N624	The associated Workers' Compensation claim has been withdrawn.	07/15/2013
N625	Missing/Incomplete/Invalid Workers' Compensation Claim Number.	07/15/2013
N626	New or established patient E/M codes are not payable with chiropractic care codes.	07/15/2013
N627	Service not payable per managed care contract.	07/15/2013
N628	Out-patient follow up visits on the same date of service as a scheduled test or treatment is disallowed.	07/15/2013
N629	Reviews/documentation/notes/summaries/reports/charts not requested.	07/15/2013
N630	Referral not authorized by attending physician.	07/15/2013
N631	Medical Fee Schedule does not list this code. An allowance was made for a comparable service.	07/15/2013
N632	According to the Official Medical Fee Schedule this service has a relative value of zero and therefore no payment is due.	07/15/2013
N633	Additional anesthesia time units are not allowed.	07/15/2013
N634	The allowance is calculated based on anesthesia time units.	07/15/2013
N635	The Allowance is calculated based on the anesthesia base units plus time.	07/15/2013
N636	Adjusted because this is reimbursable only once per injury.	07/15/2013
N637	Consultations are not allowed once treatment has been rendered by the same provider.	07/15/2013
N638	Reimbursement has been made according to the home health fee schedule.	07/15/2013
N639	Reimbursement has been made according to the inpatient rehabilitation facilities fee schedule.	07/15/2013
N640	Exceeds number/frequency approved/allowed within time period.	07/15/2013
N641	Reimbursement has been based on the number of body areas rated.	07/15/2013
N642	Adjusted when billed as individual tests instead of as a panel.	07/15/2013
N643	The services billed are considered Covered or Non-Covered (NC)	07/15/2013

Code	Current Narrative	Effective Date
	in the applicable state fee schedule.	
N644	Reimbursement has been made according to the bilateral procedure rule.	07/15/2013
N645	Mark-up allowance	07/15/2013
N646	Reimbursement has been adjusted based on the guidelines for an assistant.	07/15/2013
N647	Adjusted based on diagnosis-related group (DRG).	07/15/2013
N648	Adjusted based on Stop Loss.	07/15/2013
N649	Payment based on invoice.	07/15/2013
N650	This policy was not in effect for this date of loss. No coverage is available.	07/15/2013
N651	No Personal Injury Protection/Medical Payments Coverage on the policy at the time of the loss.	07/15/2013
N652	The date of service is before the date of loss.	07/15/2013
N653	The date of injury does not match the reported date of loss.	07/15/2013
N654	Adjusted based on achievement of maximum medical improvement (MMI).	07/15/2013
N655	Payment based on provider's geographic region.	07/15/2013
N656	An interest payment is being made because benefits are being paid outside the statutory requirement.	07/15/2013
N657	This should be billed with the appropriate code for these services.	07/15/2013
N658	The billed service(s) are not considered medical expenses.	07/15/2013
N659	This item is exempt from sales tax.	07/15/2013
N660	Sales tax has been included in the reimbursement.	07/15/2013
N661	Documentation does not support that the services rendered were medically necessary.	07/15/2013
N662	Alert: Consideration of payment will be made upon receipt of a final bill.	07/15/2013
N663	Adjusted based on an agreed amount.	07/15/2013
N664	Adjusted based on a legal settlement.	07/15/2013
N665	Services by an unlicensed provider are not reimbursable.	07/15/2013
N666	Only one evaluation and management code at this service level is covered during the course of care.	07/15/2013
N667	Missing prescription	07/15/2013

Code	Current Narrative	Effective Date
N668	Incomplete/invalid prescription	07/15/2013
N669	Adjusted based on the Medicare fee schedule.	07/15/2013
N670	This service code has been identified as the primary procedure code subject to the Medicare Multiple Procedure Payment Reduction (MPPR) rule.	07/15/2013
N671	Payment based on a jurisdiction cost-charge ratio.	07/15/2013
N672	Alert: Amount applied to Health Insurance Offset.	07/15/2013
N673	Reimbursement has been calculated based on an outpatient per diem or an outpatient factor and/or fee schedule amount.	07/15/2013
N674	Not covered unless a pre-requisite procedure/service has been provided.	07/15/2013
N675	Additional information is required from the injured party.	07/15/2013
N676	Service does not qualify for payment under the Outpatient Facility Fee Schedule.	07/15/2013

Modified Codes – RARC

Code	Current Narrative	Effective Date
N1	Alert: You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract, plan benefit documents or jurisdiction statutes.	07/15/2013
N7	Alert: Processing of this claim/service has included consideration under Major Medical provisions.	07/15/2013
N10	Payment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	07/15/2013
N441	This missed/cancelled appointment is not covered.	07/15/2013

Deactivated Codes – RARC NONE

Additional Information

The official instruction, CR 8422 issued to your MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2776CP.pdf on the CMS website. If you have any questions, please contact your MAC at their toll-free number, which may be found at

http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.