MLN Matters®
Information for Medicare Fee-for-Service Health Care Professionals

News Flash – A Special Edition MLN Matters provider education article is now available at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0904.pdf* on the CMS website. This Special Edition article alerts providers regarding the implementation of HIPAA 5010 which presents substantial changes in the content of the data that providers submit with their claims as well as the data available to them in response to their electronic inquiries and outlines how providers need to plan for implementation of these changes.

MLN Matters® Number: MM6453

Related Change Request (CR) #: 6453

Related CR Release Date: May 15, 2009

Effective Date: July 1, 2009

Related CR Transmittal #: R1734

Implementation Date: July 6, 2009

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

Provider Types Affected

Physicians, providers, and suppliers who submit claims to Medicare contractors (carriers, fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), Medicare Administrative Contractors (MACs), durable medical equipment Medicare Administrative Contractors (DME MACs)) for services.

Provider Action Needed

CR 6453, from which this article is taken, announces the latest update of Remittance Advice Remark Codes (RARCs) and Claim Adjustment Reason Codes (CARCs), effective July 1, 2009. Be sure billing staff are aware of these changes.

Background

The reason and remark code sets are used to report payment adjustments in remittance advice transactions. The reason codes are also used in some coordination-of-benefits (COB) transactions. The RARC list is maintained by the Centers for Medicare & Medicaid Services (CMS), and used by all payers; and additions, deactivations, and modifications to it may be initiated by any health care

Disclaimer
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

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

The CARC list is maintained by a national Code Maintenance committee that meets when X12 meets for their trimester meetings (occurring in January/February, June, and September/October) to make decisions about additions, modifications, and retirement of existing reason codes. The CARC list is also updated 3 times a year – in early March, July, and November along with the RARC list.

Both code lists are posted at *http://www.wpc-edi.com/Codes* on the Internet. The lists at the end of the Additional Information section of this article summarize the latest changes to these lists, as announced in CR 6453.

CMS has also developed a tool to help you search for a specific category of remark code and that tool is available at *http://www.cmsremarkcodes.info* on the Internet. Note that this website does not replace the Washington Publishing Company (WPC) site. That site is *http://www.wpc-edi.com/Codes* and, should there be any discrepancies in what is posted at the CMS site and the WPC site, consider the WPC site to be correct.

Additional Information

As a reminder, CR 6336 noted that CARC 17 is being replaced with 2 new CARCs:

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

To see the official instruction (CR6453) issued to your Medicare Carrier, RHHI, DME/MAC, FI and/or MAC refer to *http://www.cms.hhs.gov/Transmittals/downloads/R1734CP.pdf* on the CMS website.

For additional information about Remittance Advice, please refer to Understanding the Remittance Advice (RA): A Guide for Medicare Providers, Physicians, Suppliers, and Billers at

Disclaimer
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf on the CMS website.

If you have questions, please contact your Medicare Carrier, RHHI, DME/MAC, FI and/or MAC at their toll-free number which may be found at http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS website.

New Codes - CARC:

Code	Current Narrative	Effective Date per WPC Posting
229	Partial charge amount not considered by Medicare due to the initial claim Type of Bill being 12X. Note: This code can only be used in the 837 transaction to convey Coordination of Benefits information when the secondary payer's cost avoidance policy allows providers to bypass claim submission to a prior payer. Use Group Code PR.	1/25/2009
230	No available or correlating CPT/HCPCS code to describe this service, Note: Used only by Property and Casualty	1/25/2009

Modified Codes – CARC:

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

Deactivated Codes - CARC

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

Disclaimer
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

New Codes - RARC:

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

Modified Codes – RARC:

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

Deactivated Codes – RARC

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

Disclaimer
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.