CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1862	**Date: November 27, 2009**
	Change Request 6742

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

I. SUMMARY OF CHANGES: This Change Request (CR) instructs contractors to add or modify reason and remark codes that have been added or modified since CR 6604. This CR also instructs Shared System Maintainers (SSMs) to deactivate the codes that have been deactivated since CR 6604, and instructs SSMs and CEDI to accept deactivated codes in derivative messages in some specific situations. Additionally this CR instructs VIPs to update Medicare Remit Easy Print (MREP). This Recurring Update Notification applies to Chapter 22, Sections 60.1 and 60.2.

New / Revised Material
Effective Date: January 1, 2010
Implementation Date: January 4, 2010

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
N/A	

III. FUNDING:
SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENT:
Recurring Update Notification

**Unless otherwise specified, the effective date is the date of service.*

Attachment – Recurring Update Notification

Pub. 100-04	Transmittal: 1862	Date: November 27, 2009	Change Request: 6742

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

Effective Date: January 1, 2010

Implementation Date: January 4, 2010

I. GENERAL INFORMATION

A Background: The Health Insurance Portability and Accountability Act (HIPAA) of 1996 instructs health plans to be able to conduct standard electronic transactions adopted under HIPAA using valid standard codes. Medicare policy states that Claim Adjustment Reason Codes (CARCs) are required in the remittance advice and coordination of benefits transactions. Medicare policy further states that appropriate Remittance Advice Remark Codes (RARCs) that provide either supplemental explanation for a monetary adjustment or policy information 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 which implements the policy change, in addition to the regular code update notification. If a modification has been initiated by an entity other than CMS for a code currently used by Medicare, contractors shall use the modified code even though the modification was not initiated by Medicare. **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 at 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 WPC Web site because the code list is updated 3 times a year and may not align with the Medicare release schedule. Please note that 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 shall not use any deactivated reason and/or remark code past the deactivation date whether the deactivation is requested by Medicare or any other entity. **The regular code update CR will establish the implementation date for all modifications and deactivations for Medicare contractors and the SSMs. If another specific CR has been issued by another CMS component with a different implementation date for a specific deactivation or modification, the earlier of the two dates will apply for Medicare implementation**. This recurring CR lists only the changes that have been approved since the last code update CR, and does not provide a complete list of new/modified/deactivated codes. You must get the complete list for both CARC and RARC from the WPC Web site that is updated 3 times a year – around March 1, July 1, and November 1.

WPC Web site address:

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

The WPC Web site has 4 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.

Claim Adjustment Reason Code (CARC):
A national code maintenance committee maintains the health care (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 3 times a year around early March, July, and November. To access the list go to:
http://www.wpc-edi.com/Codes

The new codes usually become effective when published. Any modification or deactivation becomes effective on the next quarterly release date (April 1 or July 1 or October 1 or January 1) or later 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 the next quarterly release date. A health plan may decide to implement a code deactivation before the actual effective date posted at WPC Web site as long as the deactivated code is allowed to come in on COB claims if the previous payer has 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.

Following a decision taken by the X12 835 work group, Medicare is not going to print the additional note with a CARC if the note instructs payers how the specific CARC should be used but will print a note that helps providers. For example:

16 - Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

Should be printed on the Standard Paper Remit or the MREP RA or the PC Print RA as:

16 - Claim/service lacks information which is needed for adjudication.

50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. This change to be effective 04/01/2010: These are non-covered services because this is not deemed a 'medical necessity' by the payer. Note: Refer to the 835 REF Segment: Healthcare Policy Identification, if present.

Should be printed on the Standard Paper Remit or the MREP RA or the PC Print RA on or after 4/1/2010 as:

50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer.
Note: Refer to the 835 REF Segment: Healthcare Policy Identification, if present.

New Codes – CARC:

Code	Current Narrative	Effective Date per WPC Posting
232	Institutional Transfer Amount. Note - Applies to institutional claims only and explains the DRG amount difference when the patient care crosses multiple institutions. .	11/1/2009
D23	This dual eligible patient is covered by Medicare Part D per Medicare Retro-Eligibility – Must also include Remittance Advice Remark Code	11/1/2009

Modified Codes – CARC:

Code	Modified Narrative	Effective Date per WPC Posting
4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	7/1/2010
5	The procedure code/bill type is inconsistent with the place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	7/1/2010
6	The procedure/revenue code is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	7/1/2010
7	The procedure/revenue code is inconsistent with the patient's gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	7/1/2010
8	The procedure code is inconsistent with the provider type/specialty (taxonomy). Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	7/1/2010
9	The diagnosis is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	7/1/2010

10	The diagnosis is inconsistent with the patient's gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	7/1/2010
11	The diagnosis is inconsistent with the procedure. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	7/1/2010
12	The diagnosis is inconsistent with the provider type. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	7/1/2010
49	These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	7/1/2010
51	These are non-covered services because this is a pre-existing condition. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	7/1/2010
61	Penalty for failure to obtain second surgical opinion. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	7/1/2010
96	Non-covered charge(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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	7/1/2010
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	7/1/2010
107	Related or qualifying claim/service was not identified on the claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	7/1/2010

108	Rent/purchase guidelines were not met. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	7/1/2010
152	Payer deems the information submitted does not support this length of service.	7/1/2010
167	This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	7/1/2010
170	Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	7/1/2010
171	Payment is denied when performed/billed by this type of provider in this type of facility. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	7/1/2010
172	Payment is adjusted when performed/billed by a provider of this specialty. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	7/1/2010
179	Patient has not met the required waiting requirements. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	7/1/2010
183	The referring provider is not eligible to refer the service billed. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	7/1/2010
184	The prescribing/ordering provider is not eligible to prescribe/order the service billed. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	7/1/2010

185	The rendering provider is not eligible to perform the service billed. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	7/1/2010
222	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	7/1/2010
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	7/1/2010
B8	Alternative services were available, and should have been utilized. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	7/1/2010
B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	7/1/2010
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.)	7/1/2010
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.)	7/1/2010
148	Information from another provider was not provided 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.)	7/1/2010
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 NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.)	7/1/2010

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 NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.)	7/1/2010
A1	Claim/Service denied. 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.)	7/1/2010
40	Charges do not meet qualifications for emergent/urgent care. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	7/1/2010

Deactivated Codes – CARC

Code	Current Narrative	Effective Date per WPC posting
87	Transfer Amount.	1/1/2012
D23	This dual eligible patient is covered by Medicare Part D per Medicare Retro-Eligibility – Must also include Remittance Advice Remark Code	1/1/2012

Remittance Advice Remark Codes:

CMS is the national maintainer of the remittance advice remark code list. This code list is used by reference in the ASC X12 N transaction 835 (Health Care Claim Payment/Advice) version 004010A1 Implementation Guide (IG). Under HIPAA, all payers, including Medicare, have to use reason and remark codes approved by X12 recognized code set maintainers instead of proprietary codes to explain any adjustment in the claim payment. CMS as the X12 recognized maintainer of RARCs receives requests from Medicare and non-Medicare 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 shall 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. **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. Medicare contractors shall not use any deactivated reason and/or remark code past the deactivation date whether the deactivation is requested by Medicare or any other entity.** The complete list of remark codes is available at:

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

RARC list is updated 3 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 April
Any new code or any modification becomes effective when published

As mentioned earlier, specific CMS components may publish CRs in addition to the recurring code update CRs instructing contractors to use specific 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.

By January 4, 2010, contractors shall complete entry of all applicable code text changes and new codes, and the SSMs shall implement all code deactivations. Contractors must use the latest approved and valid codes in transaction 835, corresponding Standard Paper Remittance (SPR) advice, and coordination of benefits transactions.

CMS has developed a new Web site to help navigate the RARC database more easily. A tool is provided to help search if you are looking for a specific category of codes. At this site, you can find some other information that is also available from the WPC Web site. This CMS Web site address is: **http://www.cmsremarkcodes.info** (This Web site is currently being updated, and will be available in early December, 2009)

NOTE I: This Web site is not replacing the WPC Web site as the official site where the most current RARC list resides. If there is any discrepancy, **always use the list posted at the WPC Web site.**

NOTE II: Some remark codes may only provide general information that may not necessarily supplement the specific explanation provided through a reason code and in some cases another/other remark code(s) for a monetary adjustment. Codes that are "Informational" will have "Alert" in the text to identify them as informational rather than explanatory codes. These "Informational" codes may be used without any specific monetary adjustment and an associated CARC explaining that 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 CARCs -16, 96, 125, 148, 226, 227, and A1.**

New Codes – RARC:

Code	Current Narrative	Medicare Initiated

N521	Mismatch between the submitted provider information and the provider information stored in our system.	NO
N522	Duplicate of a claim processed as a crossover claim.	NO

Modified Codes – RARC:

Code	Modified Narrative	Medicare Initiated
M39	The patient is not liable for payment for this service as the advance notice of non-coverage you provided the patient did not comply with program requirements.	NO
M118	Letter to follow containing further information.	NO
N59	Please refer to your provider manual for additional program and provider information.	NO
N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	NO
N202	Additional information/explanation will be sent separately	NO

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. Additionally, for transaction 837 COB, CARC must be used. These code sets are updated 3 times a year on a regular basis. Medicare contractors shall report only currently valid codes in both the remittance advice and COB Claim transaction, and shall allow deactivated CARC and RARC in derivative messages when certain conditions are met (see BR 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 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 have not been initiated by Medicare.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6742.1	A/B MACs, carriers, DME MACs, FIs, and RHHIs shall update reason and remark codes that have been modified and apply to Medicare by January 4, 2010.	X	X	X	X	X					
6742.2	A/B MACs, carriers, DME MACs, FIs, and RHHIs shall update reason and remark codes to include new codes that apply to Medicare by January 4, 2010.	X	X	X	X	X					
6742.3	FISS, MCS, and VIPs shall make necessary programming changes so that no deactivated reason and remark code is reported in the remittance advice and no deactivated reason code is reported in the COB claim by January 4, 2010.						X	X	X		
6742.4	FISS, MCS, VIPs shall update any crosswalk between the standard reason and remark codes and the shared system internal codes provided to the contractors and make any deactivated standard code unavailable for use by the contractors by January 4, 2010.						X	X	X		
6742.5	FISS, MCS, and CEDI shall make necessary programming changes so that deactivated reason and remark codes are allowed in derivative messages after the deactivation implementation date (January 4, 2010) 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
6742.6	FISS, MCS, and VIPs shall make necessary programming changes so that deactivated reason and remark codes are allowed in derivative messages even after the deactivation implementation date (January 4, 2010) in a Reversal and Correction situation when a value of 22 in CLP02 identifies the claim to be a corrected claim.						X	X	X		
6742.7	VIPs shall update the Medicare Remit Easy Print (MREP) software to include the most current CARC and RARC lists available from the following Web site: http://www.wpc-edi.com/codes								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	
	(Note: This update is provided in a separate file since April, 2008.)										
6742.8	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 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	
6742.9	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					CEDI

IV. SUPPORTING INFORMATION

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

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Sumita Sen at sumita.sen@cms.hhs.gov or 410-786-5755

Post-Implementation Contact(s): Sumita Sen at sumita.sen@cms.hhs.gov or 410-786-5755

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers,* use only one of the following statements:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs),* include the following statement:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.