| CMS Manual System | Department of Health & Human Services (DHHS) |
|---|---|
| Pub 100-04 Medicare Claims Processing | Centers for Medicare & Medicaid Services (CMS) |
| **Transmittal 1950** | **Date: April 23, 2010** |
| | **Change Request 6901** |

**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 6742. This CR also instructs Shared System Maintainers (SSMs) to deactivate the codes that have been deactivated since CR 6742, and instructs SSMs and CEDI to accept deactivated codes in derivative messages. Additionally this CR instructs VIPs to update Medicare Remit Easy Print (MREP). This Recurring Update Notification (RUN) can be found in Pub.100-4, Chapter 22, Section 60.

**EFFECTIVE DATE: July 1, 2010**
**IMPLEMENTATION DATE: July 6, 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:**
**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: 1950 | Date: April 23, 2010 | Change Request: 6901 |
|---|---|---|---|

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

**Effective Date**: July 1, 2010

**Implementation Date:** July 6, 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 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 at the WPC Web site.** Contractors must 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 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 CR will establish the implementation date for all modifications, deactivations, and any new code for Medicare contractors and the SSMs. 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**. **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 – 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 3 or 4 times a year according to the Medicare release schedule (see above for exception).

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.

**NOTE**: **This is the official Website for both the Claim Adjustment Reason and Remittance Advice Remark codes, and available to the industry. If there is any discrepancy between the text posted at this Website and the text in the code update recurring CR, use what is posted at WPC Website.**

**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 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.

The following new Claim Adjustment Reason Codes were approved by the Code Committee in January, and must be implemented, if appropriate, by July 6, 2010.

**New Codes – CARC:**

| Code | Current Narrative | Effective Date per WPC Posting |
|---|---|---|
| 233 | Services/charges related to the treatment of a hospital-acquired condition or preventable medical error. . | 1/24/2010 |
| 234 | This procedure is not paid separately. 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.) | 1/24/2010 |

**Modified Codes – CARC:**

NONE

**Deactivated Codes – CARC:**

NONE

**Printing the note with CARCs:**

**In CR 6742, the following examples were given in relation to what "Note" should be printed on the paper remit, and MREP/PC Print RA:**

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.

**Since CR 6742 was written, the codes that have the note (e.g., 50) about the 835 REF segment changed the implementation date from 4/1/2010 to 7/1/2010 with a change in the text. The following text is now approved to be implemented on 7/1/2010: "Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present". To avoid any confusion to the provider community, do not print the text before CR 6901 is implemented on 7/6/2010, and print the updated note that is now available to the provider community through the WPC Website. Currently the following CARC codes have the note starting from 7/1/2010: 4, 5, 6, 7, 8, 9, 10, 11, 12, 40, 49, 50, 51, 54, 55, 56, 58, 59, 61, 96, 97, 107, 108, 152, 167, 170, 171, 172, 179, 183, 184, 185, 222, 231, B7, B8, and B15. The list of codes with this note about the 835 Healthcare Policy Segment may change in the future, and you must download the most recently updated RARC list from the WPC website to get a comprehensive list of codes that should include the note about the 835 Healthcare Policy Identification Segment .**

**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 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. **Contractors must 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 are not to 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 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 July 6, 2010 contractors must complete entry of all applicable code text changes and new codes, and the SSMs must implement all code deactivations. Contractors must use the latest approved and valid codes in the 835, corresponding Standard Paper Remittance (SPR) advice, and coordination of benefits transactions.

CMS has developed a 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 being updated, and will be available later. Currently it points to the WPC Web site.)

**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, 234, A1, and D23.**

**New Codes – RARC:**

| Code | Current Narrative | Medicare Initiated |
|---|---|---|
| N523 | The limitation on outlier payments defined by this payer for this service period has been met. The outlier payment otherwise applicable to this claim has not been paid. | YES |
| N524 | Based on policy this payment constitutes payment in full. | NO |
| N525 | These services are not covered when performed within the global period of another service. | NO |
| N526 | Not qualified for recovery based on employer size. | YES |
| N527 | We processed this claim as the primary payer prior to receiving the recovery demand. | YES |
| N528 | Patient is entitled to benefits for Institutional Services. | YES |
| N529 | Patient is entitled to benefits for Professional Services | YES |
| N530 | Our records indicate a mismatch in enrollment information for this patient | YES |
| N531 | Not qualified for recovery based on direct payment of premium. | YES |
| N532 | Not qualified for recovery based on disability and working status. | YES |

**Modified Codes – RARC:**

| Code | Modified Narrative | Medicare Initiated |
|---|---|---|
| N216 | We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit package | NO |
| N522 | Duplicate of a claim processed, or to be processed, as a crossover claim. | 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 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 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 | |
| 6901.1 | A/B MACs, carriers, DME MACs, FIs, and RHHIs shall update reason and remark codes that have been modified and apply to Medicare by July 6, 2010. | X | X | X | X | X | | | | | |
| 6901.2 | A/B MACs, carriers, DME MACs, FIs, and RHHIs shall update reason and remark codes to include new codes that apply to Medicare by July 6, 2010. | X | X | X | X | X | | | | | |
| 6901.3 | 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 July 6, 2010. | | | | | | X | X | X | | |
| 6901.4 | 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 July 6, 2010. | | | | | | X | X | X | | |
| 6901.5 | 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 (July 6, 2010) when:<br>● Medicare is not primary; and<br>● the COB claim is received after the deactivation effective date; and<br>● the date in DTP03 in Loop 2430 or 2330B in COB 837 transaction is less than the deactivation effective date as | | | | | | X | X | | | CEDI |

| 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 | |
| | posted on the WPC web site. | | | | | | | | | | |
| 6901.6 | 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 (July 6, 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 | | |
| 6901.7 | 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 (Note: This update is provided in a separate file since April, 2008.) | | | | | | | | X | | |
| 6901.8 | VIPs shall update the Medicare Remit Easy Print (MREP) software so that it captures any change in the information reported in the remittance advice (e.g., addition of ICN and HICN in the PLB segment in case of any type of recoupment). | | | | | | | | X | | |
| 6901.9 | 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 | |
| 6901.10 | 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 | X | | X | X | X | | | | | CEDI |

| 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 | |
| | 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. | | | | | | | | | | |

## 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.