DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

NEW product from the Medicare Learning Network® (MLN)

- "Vaccine Payments Under Medicare Part D", Fact Sheet, ICN 908764, downloadable

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| MLN Matters® Number: MM8561 | Related Change Request (CR) #: CR 8561 |
| Related CR Release Date: January 10, 2014 | Effective Date: April 1, 2014 |
| Related CR Transmittal #: R2855CP | Implementation Date: April 7, 2014 |

# Remittance Advice Remark Code (RARC) and Claims Adjustment Reason Code (CARC) and Medicare Remit Easy Print (MREP) and PC Print Update

## Provider Types Affected

This MLN Matters® Article is intended for physicians, other providers, and suppliers who submit claims to Medicare Claims Administration Contractors (MACs) for services provided to Medicare beneficiaries.

## Provider Action Needed

This article is based on Change Request (CR) 8561 which updates the CARC and RARC lists that are effective on April 1, 2014. CR 8561 also instructs Fiscal Intermediary Standard System (FISS) and VIPs Medicare System (VMS) maintainers to update PC Print and Medicare Remit Easy Print (MREP) software by April 7, 2014. Make sure that your billing staffs are aware of these updates and that they obtain the updated MREP or PC Print software.

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## 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 CARCs and appropriate RARCs 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 (COBs)).

The CARC and RARC changes that impact Medicare are usually requested by the Centers for Medicare & Medicaid Services (CMS) staff in conjunction with a policy change. If a modification has been initiated by an entity other than CMS for a code currently used by Medicare, MACs must either use the modified code or use another code if the modification makes the modified code inappropriate to explain the specific reason for adjustment.

CARC and RARC code sets are updated three times a year on a regular basis. CR 8561 lists only the changes that have been approved since the last code update issued on August 30, 2013 in CR 8422 , Transmittal R2776CP and does not provide a complete list of codes for these two code sets. The MLN Matters® Article corresponding to CR 8422, MM8422, can be found at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8422.pdf on the CMS website.

Note: If there is 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 CR 8422

The following tables list the changes in the CARC database since the last code update CR8422. 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 |
|---|---|---|
| 257 | The disposition of the claim/service is pending during the premium payment grace period, per Health Insurance Exchange requirements. (Use only with Group Code OA) | 11/01/2013 |
| 258 | Claim/service not covered when patient is in custody/incarcerated. Applicable federal, state or local authority may cover the claim/service. | 11/01/2013 |

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| Code | Narrative | Effective Date |
|---|---|---|
| P1 | State-mandated Requirement for Property and Casualty, see Claim Payment Remarks Code for specific explanation. To be used for Property and Casualty only. | 11/01/2013 |
| P2 | Not a work related injury/illness and thus not the liability of the workers' compensation carrier 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). To be used for Workers' Compensation only. | 11/01/2013 |
| P3 | Workers' Compensation case settled. Patient is responsible for amount of this claim/service through WC 'Medicare set aside arrangement' or other agreement. To be used for Workers' Compensation only. (Use only with Group Code PR) | 11/01/2013 |
| P4 | Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment. 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). To be used for Workers' Compensation only | 11/01/2013 |
| P5 | Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement. To be used for Property and Casualty only. | 11/01/2013 |
| P6 | Based on entitlement to benefits. 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). To be used for Property and Casualty only. | 11/01/2013 |
| P7 | The applicable fee schedule/fee database does not contain the billed code. Please resubmit a bill with the appropriate fee schedule/fee database code(s) that best describe the service(s) provided and supporting documentation if required. To be used for Property and Casualty only. | 11/01/2013 |

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| Code | Narrative | Effective Date |
|---|---|---|
| P8 | 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). To be used for Property and Casualty only. | 11/01/2013 |
| P9 | No available or correlating CPT/HCPCS code to describe this service. To be used for Property and Casualty only. | 11/01/2013 |
| P10 | Payment reduced to zero due to litigation. Additional information will be sent following the conclusion of litigation. To be used for Property and Casualty only. | 11/01/2013 |
| P11 | The disposition of the related Property & Casualty claim (injury or illness) is pending due to litigation. To be used for Property and Casualty only. (Use only with Group Code OA) | 11/01/2013 |
| P12 | 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. To be used for Workers' Compensation only. | 11/01/2013 |
| P13 | 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. | 11/01/2013 |
| P14 | The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. To be used for Property and Casualty only. | 11/01/2013 |
| P15 | Workers' Compensation Medical Treatment Guideline Adjustment. To be used for Workers' Compensation only. | 11/01/2013 |

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| Code | Narrative | Effective Date |
|---|---|---|
| P16 | Medical provider not authorized/certified to provide treatment to injured workers in this jurisdiction. To be used for Workers' Compensation only. (Use with Group Code CO or OA | 11/01/2013 |
| P17 | Referral not authorized by attending physician per regulatory requirement. To be used for Property and Casualty only | 11/01/2013 |
| P18 | Procedure is not listed in the jurisdiction fee schedule. An allowance has been made for a comparable service. To be used for Property and Casualty only. | 11/01/2013 |
| P19 | Procedure has a relative value of zero in the jurisdiction fee schedule, therefore no payment is due. To be used for Property and Casualty only. | 11/01/2013 |
| P20 | Service not paid under jurisdiction allowed outpatient facility fee schedule. To be used for Property and Casualty only. | 11/01/2013 |
| P21 | 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 Property and Casualty Auto only. | 11/01/2013 |
| P22 | Payment adjusted 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 Property and Casualty Auto only. | 11/01/2013 |
| P23 | 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 Property and Casualty Auto only. | 11/01/2013 |

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## Modified Codes – CARC

| Code | Modified Narrative | Effective Date |
|---|---|---|
| 49 | This is a non-covered service because it is a routine/preventive exam or a diagnostic/screening procedure done in conjunction with a routine/preventive exam. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. | 11/01/2013 |
| 253 | Sequestration - reduction in federal payment | 11/01/2013 |

## Deactivated Codes – CARC

| Code | Current Narrative | Effective Date |
|---|---|---|
| 162 | State-mandated Requirement for Property and Casualty, see Claim Payment Remarks Code for specific explanation. | 07/01/2014 |
| 191 | Not a work related injury/illness and thus not the liability of the workers' compensation carrier 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) | 07/01/2014 |
| 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) | 07/01/2014 |
| 214 | Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment. 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). To be used for Workers' Compensation only | 07/01/2014 |
| 217 | Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement. (Note: To be used for Property and Casualty only) | 07/01/2014 |

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| Code | Current Narrative | Effective Date |
|---|---|---|
| 218 | Based on entitlement to benefits. 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). To be used for Workers' Compensation only | 07/01/2014 |
| 220 | The applicable fee schedule/fee database does not contain the billed code. Please resubmit a bill with the appropriate fee schedule/fee database code(s) that best describe the service(s) provided and supporting documentation if required. (Note: To be used for Property and Casualty only) | 07/01/2014 |
| 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) | 07/01/2014 |
| 230 | No available or correlating CPT/HCPCS code to describe this service. Note: Used only by Property and Casualty. | 07/01/2014 |
| 244 | Payment reduced to zero due to litigation. Additional information will be sent following the conclusion of litigation. To be used for Property & Casualty only. | 07/01/2014 |
| 255 | The disposition of the related Property & Casualty claim (injury or illness) is pending due to litigation. (Use only with Group Code OA) | 07/01/2014 |
| 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. | 07/01/2014 |
| 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 | 07/01/2014 |

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| Code | Current Narrative | Effective Date |
|---|---|---|
| | '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. | |
| W3 | The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. For use by Property and Casualty only. | 07/01/2014 |
| W4 | Workers' Compensation Medical Treatment Guideline Adjustment. | 07/01/2014 |
| W5 | Medical provider not authorized/certified to provide treatment to injured workers in this jurisdiction. (Use with Group Code CO or OA) | 07/01/2014 |
| W6 | Referral not authorized by attending physician per regulatory requirement. | 07/01/2014 |
| W7 | Procedure is not listed in the jurisdiction fee schedule. An allowance has been made for a comparable service. | 07/01/2014 |
| W8 | Procedure has a relative value of zero in the jurisdiction fee schedule, therefore no payment is due. | 07/01/2014 |
| W9 | Service not paid under jurisdiction allowed outpatient facility fee schedule. | 07/01/2014 |
| 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. | 07/01/2014 |
| Y2 | Payment adjusted 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. | 07/01/2014 |
| 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 | 07/01/2014 |

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| Code | Current Narrative | Effective Date |
|---|---|---|
| | 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. | |

## Changes in RARC List since CR 8422

The following are changes in the RARC database since the last code update CR 8422. The full RARC list can be downloaded from the WPC website available at http://wpc-edi.com/Reference on the Internet.

New Codes – RARC:

| Code | Narrative | Effective Date |
|---|---|---|
| N677 | Alert: Films/Images will not be returned. | 11/1/2013 |
| N678 | Missing post-operative images/visual field results. | 11/1/2013 |
| N679 | Incomplete/Invalid post-operative images/visual field results. | 11/1/2013 |
| N680 | Missing/Incomplete/Invalid date of previous dental extractions. | 11/1/2013 |
| N681 | Missing/Incomplete/Invalid full arch series. | 11/1/2013 |
| N682 | Missing/Incomplete/Invalid history of prior periodontal therapy/maintenance. | 11/1/2013 |
| N683 | Missing/Incomplete/Invalid prior treatment documentation. | 11/1/2013 |
| N684 | Payment denied as this is a specialty claim submitted as a general claim. | 11/1/2013 |
| N685 | Missing/Incomplete/Invalid Prosthesis, Crown or Inlay Code. | 11/1/2013 |
| N686 | Missing/incomplete/invalid questionnaire needed to complete payment determination. | 11/1/2013 |

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| Code | Narrative | Effective Date |
|---|---|---|
| N687 | Alert - This reversal is due to a retroactive disenrollment.<br>(Note: To be used with claim/service reversal) | 11/1/2013 |
| N688 | Alert – This reversal is due to a medical or utilization review decision.<br>(Note: To be used with claim/service reversal) | 11/1/2013 |
| N689 | Alert –This reversal is due to a retroactive rate change.<br>(Note: To be used with claim/service reversal) | 11/1/2013 |
| N690 | Alert – This reversal is due to a provider submitted appeal.<br>(Note: To be used with claim/service reversal) | 11/1/2013 |
| N691 | Alert – This reversal is due to a patient submitted appeal.<br>(Note: To be used with claim/service reversal) | 11/1/2013 |
| N692 | Alert – This reversal is due to an incorrect rate on the initial adjudication<br>(Note: To be used with claim/service reversal) | 11/1/2013 |
| N693 | Alert – This reversal is due to a cancelation of the claim by the provider. | 11/1/2013 |
| N694 | Alert – This reversal is due to a resubmission/change to the claim by the provider. | 11/1/2013 |
| N695 | Alert – This reversal is due to incorrect patient financial responsibility information on the initial adjudication. | 11/1/2013 |
| N696 | Alert – This reversal is due to a Coordination of Benefits or Third Party Liability Recovery retroactive adjustment.<br>(Note: To be used with claim/service reversal) | 11/1/2013 |
| N697 | Alert – This reversal is due to a payer's retroactive contract incentive program adjustment.<br>(Note: To be used with claim/service reversal) | 11/1/2013 |
| N698 | Alert – This reversal is due to non-payment of the Health Insurance Exchange premiums by the end of the premium payment grace period, resulting in loss of coverage.<br>(Note: To be used with claim/service reversal) | 11/1/2013 |

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Modified Codes – RARC

| Code | Modified 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. | 11/01/2013 |
| N103 | Records indicate this patient was a prisoner or in custody of a Federal, State, or local authority when the service was rendered. This payer does not cover items and services furnished to an individual while he or she is in custody under a penal statute or rule, unless under State or local law, the individual is personally liable for the cost of his or her health care while in custody and the State or local government pursues the collection of such debt in the same way and with the same vigor as the collection of its other debts. The provider can collect from the Federal/State/ Local Authority as appropriate. | 11/01/2013 |
| N178 | Missing pre-operative images/visual field results | 11/01/2013 |
| N244 | Incomplete/Invalid pre-operative images/visual field results. | 11/01/2013 |
| N597 | Adjusted based on a medical/dental provider's apportionment of care between related injuries and other unrelated medical/dental conditions/injuries. | 11/01/2013 |

Deactivated Codes – RARC

| Code | Current Narrative | Effective Date |
|---|---|---|
| N365 | This procedure code is not payable. It is for reporting/information purposes only. | 07/01/2014 |
| N627 | Service not payable per managed care contract. | 07/01/2014 |
| N632 | According to the Official Medical Fee Schedule this service has a relative value of zero and therefore no payment is due. | 07/01/2014 |

## Additional Information

The official instruction, CR 8561, issued to your MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2855CP.pdf on the CMS website.

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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.

News Flash - Generally, Medicare Part B covers one flu vaccination and its administration per flu season for beneficiaries without co-pay or deductible. Now is the perfect time to vaccinate beneficiaries. Health care providers are encouraged to get a flu vaccine to help protect themselves from the flu and to keep from spreading it to their family, co-workers, and patients. Note: The flu vaccine is not a Part D-covered drug. For more information, visit:

- MLN Matters® Article #MM8433, "Influenza Vaccine Payment Allowances - Annual Update for 2013-2014 Season"
- MLN Matters® Article #SE1336, "2013-2014 Influenza (Flu) Resources for Health Care Professionals"
- HealthMap Vaccine Finder - a free, online service where users can search for locations offering flu and other adult vaccines. While some providers may offer flu vaccines, those that don't can help their patients locate flu vaccines within their local community.

The CDC website for Free Resources, including prescription-style tear-pads that allow you to give a customized flu shot reminder to patients at high-risk for complications from the flu.

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