DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

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MLN Matters® Number: MM8703 | **Related Change Request (CR) #: CR 8703**

Related CR Release Date: April 4, 2014 | **Effective Date: July 1, 2014**

Related CR Transmittal #: R2920CP | **Implementation Date: July 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 for physicians, providers, and suppliers sending claims to Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 8703, which updates the Claims Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) lists and also instructs Medicare systems maintainers to update the Medicare Remit Easy Print (MREP) and PC Print by July 1, 2014. Make sure that your billing staffs are aware of these updates and that they obtain the updated MREP or PC Print software if you use that 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).

The CARC and RARC changes that affect 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 8703 lists only the changes that have been approved since the last code update (CR 8561, Transmittal 2855, issued on January 10, 2014, with the related MLN Matters® article available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8561.pdf** on the CMS website), and does not provide a complete list of codes for these two code sets.

Changes in CARC List since CR 8561

The following tables list the changes in the CARC database since the last code update in CR8561. The full CARC list is available from the Washington Publishing Company (WPC) website at **http://wpc-edi.com/Reference** on the Internet.

New Codes – CARC

Code	Narrative	Effective Date
259	Additional payment for Dental/Vision service utilization.	01/26/2014
260	Processed under Medicaid ACA Enhanced Fee Schedule.	01/26/2014

Modified Codes – CARC

Code	Modified Narrative	Effective Date
257	The disposition of the claim/service is undetermined during the premium payment grace period, per Health Insurance Exchange requirements. This claim/service will be reversed and corrected when the grace period ends (due to premium payment or lack of premium payment). (Use only with Group Code OA) Notes: To be used for months 2 and 3 in the grace period.	01/26/2014

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Deactivated Codes – CARC

Code	Current Narrative	Effective Date
A7	Presumptive Payment Adjustment	07/01/2015

Changes in RARC List since CR 8561

The following tables list the changes in the RARC database since the last code update in CR8561. The full RARC list is available from the WPC website at **http://wpc-edi.com/Reference** on the Internet.

New Codes – RARC

Code	Narrative	Effective Date
N699	Payment adjusted based on the Physician Quality Reporting System (PQRS) Incentive Program.	3/1/2014
N700	Payment adjusted based on the Electronic Health Records (EHR) Incentive Program.	3/1/2014
N701	Payment adjusted based on the Value-based Payment Modifier.	3/1/2014
N702	Decision based on review of previously adjudicated claims or for claims in process for the same/similar type of services	3/1/2014
N703	This service is incompatible with previously adjudicated claims or claims in process.	3/1/2014
N704	Alert: You may not appeal this decision but can resubmit this claim/service with corrected information if warranted.	3/1/2014
N705	Incomplete/invalid documentation.	3/1/2014
N706	Missing documentation.	3/1/2014
N707	Incomplete/invalid orders.	3/1/2014
N708	Missing orders.	3/1/2014
N709	Incomplete/invalid notes.	3/1/2014
N710	Missing notes.	3/1/2014
N711	Incomplete/invalid summary.	3/1/2014
N712	Missing summary.	3/1/2014
N713	Incomplete/invalid report.	3/1/2014
N714	Missing report.	3/1/2014

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Code	Narrative	Effective Date
N715	Incomplete/invalid chart	3/1/2014
N716	Missing chart.	3/1/2014
N717	Incomplete/Invalid documentation of face-to-face examination	3/1/2014
N718	Missing documentation of face-to-face examination.	3/1/2014
N719	Penalty applied based on plan requirements not being met.	3/1/2014
N720	Alert: The patient overpaid you. You may need to issue the patient a refund for the difference between the patient's payment and the amount shown as patient responsibility on this notice.	3/1/2014
N721	This service is only covered when performed as part of a clinical trial.	3/1/2014
N722	Patient must use Workers' Compensation Set-Aside (WCSA) funds to pay for the medical service or item.	3/1/2014
N723	Patient must use Liability set-aside (LSA) funds to pay for the medical service or item.	3/1/2014
N724	Patient must use No-Fault set-aside (NFSA) funds to pay for the medical service or item.	3/1/2014
N725	A liability insurer has reported having ongoing responsibility for medical services (ORM) for this diagnosis.	3/1/2014
N726	A conditional payment is not allowed.	3/1/2014
N727	A no-fault insurer has reported having ongoing responsibility for medical services (ORM) for this diagnosis.	3/1/2014
N728	A workers' compensation insurer has reported having ongoing responsibility for medical services (ORM) for this diagnosis.	3/1/2014

Modified Codes – RARC

Code	Modified Narrative	Effective Date
MA50	Missing/incomplete/invalid Investigational Device Exemption number or Clinical Trial number. Start: 01/01/1997. Last modified: 03/01/2014. Notes: (Modified 2/28/03, 3/1/2014)	3/1/2014
M77	Missing/incomplete/invalid/inappropriate place of service. Start: 01/01/1997. Last Modified: 03/01/2014. Notes: (Modified 2/28/03, 3/1/2014)	3/1/2014

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Code	Modified Narrative	Effective Date
N29	Missing documentation/orders/notes/summary/report/chart. Start: 01/01/2000 | Stop: 03/01/2016 | Last Modified: 03/01/2014. Notes: (Modified 2/28/03, 8/1/05, 3/1/2014) Related to N225, Explicit RARCs have been approved, this non-specific RARC will be deactivated in March 2016.	3/1/2014
N225	Incomplete/invalid documentation/orders/ notes/summary/report/ chart. Start: 08/01/2004 | Stop: 03/01/2016 | Last Modified: 03/01/2014. Notes: (Modified 8/1/05, 3/1/2014) Explicit RARCs have been approved, this non-specific RARC will be deactivated in March 2016.	3/1/2014

Deactivated Codes – RARC (There are no deactivated codes.)

Additional Information

The official instruction, CR 8703, issued to your MAC regarding this change, is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2920CP.pdf** on the CMS website.

If you have any questions, please contact your MAC at their toll-free number, which is available at **http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html** on the CMS website.

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