CMS Manual System

Pub. 100-04 Medicare Claims Processing

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 93 **Date: February 6, 2004**

CHANGE REQUEST 3122

I. SUMMARY OF CHANGES: This transmittal updates the Remittance Advice Remark Code and Claim Adjustment Reason Code lists that must be used to generate a HIPAA compliant remittance advice. Medicare contractors will be receiving subsequent updates to the Remittance Advice Remark Code and Claim Adjustment Reason Code lists every 4 months, that must be used by all Medicare contractors to generate a HIPAA compliant remittance advice.

NEW/REVISED MATERIAL - EFFECTIVE DATE: April 1, 2004
***IMPLEMENTATION DATE: April 5, 2004**

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.

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

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
	N/A

***III. FUNDING:**

These instructions shall be implemented within your current operating budget.

IV. ATTACHMENTS:

	Business Requirements
	Manual Instruction
	Confidential Requirements
	One-Time Notification
X	**Recurring Update Notification**

***Medicare contractors only**

Attachment – Recurring Update Notification

Pub. 100-04	Transmittal: 93	Date: February 6, 2004	Change Request 3122

SUBJECT: Remittance Advice Remark Code and Claim Adjustment Reason Code Update

I. GENERAL INFORMATION

A. Background: Per Health Insurance Portability and Accountability Act (HIPAA) of 1996, health plans must be able to conduct standard electronic transactions for transactions mentioned in the regulation.

X12N 835 Health Care Remittance Advice Remark Codes

The CMS is the national maintainer of the remittance advice remark code list that is one of the code lists mentioned in ASC X12 transaction 835 (Health Care Claim Payment/Advice) version 4010A1 Implementation Guide (IG). Under the Health Insurance Portability and Accountability Act (HIPAA), all payers, including Medicare, have to use reason and remark codes approved by X12 recognized maintainers instead of proprietary codes to explain any adjustment in the payment. The CMS receives a significant number of requests for new remark codes and modifications in existing remark codes from non-Medicare entities, and these additions and modifications may not impact Medicare. Traditionally, remark code changes that impact Medicare are requested by Medicare staff in conjunction with a policy change. Contractors are notified of those new/modified codes in the corresponding implementation instructions, which implement the policy change, in addition to the regular code update notification. If a modification has been initiated by an entity other than Medicare for a code currently used by Medicare, contractors must use the modified code even though the modification was not initiated by Medicare. If a new code is not initiated by Medicare, contractors do not have to use it unless otherwise instructed by Medicare. Contractors must stop using codes that have been deactivated on or before the effective date specified in the comment section if they are currently being used. The complete list of remark codes is available at:

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

and

http://www.cms.hhs.gov/providers/edi/hipaadoc.asp

The list is updated 3 times a year. By April 1, 2004, you must have completed entry of all applicable code text changes, new codes, and deactivation of codes that have been deactivated, for use in production, and to make sure that you are using the latest approved remark codes as included in any CMS instructions in your 835 version 4010A1 and subsequent versions, the corresponding standard paper remittance advice transactions, and any other ANSI X12

transaction where these codes may be used (e.g., 837 COB). The following list summarizes changes made from July 1, 2003 to October 31, 2003.

Code	Current Narrative	Medicare Initiated
N212	Changes processed under a Point of Service benefit.	

Modified Remark Codes

Code	Current Modified Narrative	Modification Date
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.	Modified 10/31/03
M68	Missing/incomplete/invalid attending, ordering, rendering, supervising or referring physician identification.	Modified 2/28/03, 10/31/03
M80	Not covered when performed during the same session/date as a previously processed service for the patient.	Modified 10/31/03
M81	You are required to code to the highest level of specificity.	Modified 10/31/03). See M76 for rest of the previous text
M84	Medical code sets used must be the codes in effect at the time of service	(Modified 10/31/03)
M116	Paid under the Competitive Bidding Demonstration project. Project is ending, and future services may not be paid under this project.	Modified 10/31/03
MA76	Missing/incomplete/invalid provider identifier for home health agency or hospice when physician is performing care plan oversight services.	(Modified 2/28/03, 10/31/03)
MA121	Missing/incomplete/invalid date the x-ray was performed.	(Modified 2/28/03, 6/30/03, 10/31/03)
N40	Missing/incomplete/invalid x-ray.	(Modified 2/28/03, 6/30/03, 10/31/03)
N157	Transportation to/from this destination is not covered.	(New Code 2/28/03) Modified 10/31/03
N160	The patient must choose an option before a payment can be made for this procedure/equipment/supply/service.	(New Code 2/28/03) Modified 10/31/03

Deactivated Remark Codes

Code	Current Modified Narrative	Deactivation Date
M33	Missing/incomplete/invalid UPIN for the ordering/referring/performing provider.	(Modified 2/28/03) Deactivated eff. 8/1/04. Refer to M68

M34	Claim lacks the CLIA certification number.	Deactivated eff. 8/1/04. Refer to MA120
M88	We cannot pay for laboratory tests unless billed by the laboratory that did the work.	Deactivated eff.8/1/04. Refer to Reason Code B20
M92	Services subjected to review under the Home Health Medical Review Initiative.	Deactivated eff. 8/1/04.
MA06	Missing/incomplete/invalid beginning and/or ending date(s).	(Modified 2/28/03) Deactivated eff. 8/1/04. Refer to MA31
MA49	Missing/incomplete/invalid six-digit provider identifier for home health agency or hospice for physician(s) performing care plan oversight services.	(Modified 2/28/03) Deactivated eff.8/1/04. Refer to MA76
MA85	Our records indicate that a primary payer exists (other than ourselves); however, you did not complete or enter accurately the insurance plan/group/program name or identification number. Enter the PlanID when effective.	Deactivated eff. 8/1/04. Refer to MA92
MA86	Missing/incomplete/invalid group or policy number of the insured for the primary coverage.	(Modified 2/28/03). Deactivated eff. 8/1/04. Refer to MA92
MA87	Missing/incomplete/invalid insured's name for the primary payer.	(Modified 2/28/03). Deactivated eff.8/1/04. Refer to MA92
MA102	Missing/incomplete/invalid name or provider identifier for the rendering/referring/ordering/supervising provider.	(Modified 2/28/03) Deactivated eff. 8/1/04. Refer to M68
N17	Per admission deductible.	Deactivated eff. 8/1/04. Refer to Reason code 1

X12 N 835 Health Care Claim Adjustment Reason Codes

The Health Care Code Maintenance Committee maintains the health care claim adjustment reason codes. The Committee meets at the beginning of each X12 trimester meeting (February, June and October) and makes decisions about additions, modifications, and retirement of existing reason codes. The updated list is posted 3 times a year after each X12 trimester meeting at http://www.wpc-edi.com/codes/Codes.asp. Select Claim Adjustment Reason Codes from the pull down menu. All reason code changes approved in September 2003 are listed here. By April 1, 2004, you must have the most current reason code set installed for production to make sure that all carriers, intermediaries, and DMERCs are using the latest approved reason codes in 835 and standard paper remittance advice transactions.

The request for a reason code change may come from non-Medicare entities. If Medicare requests a change, it may be included in a Medicare instruction in addition to this regular code update notification. The regular code update notification is issued on a periodic basis to provide a summary of changes in the reason and remark codes introduced since the last update notification, and will establish the deadline for Medicare contractors to implement the reason and remark code changes that may not already have been implemented as part of a previous Medicare policy change instruction.

A reason code may be retired if it is no longer applicable or a similar code exists. Retirements are effective for a specified future and succeeding versions, but contractors can also discontinue use of retired codes in prior versions. The regular code update notification will establish the deadline for Medicare contractors to retire a reason code that could be earlier than the version specified in the WPC posting. The committee approved the following reason code changes in September 2003.

Reason Code Changes (as of 10/31/03)

Code	Current Narrative	Notes
156	Flexible spending account payments.	New as of 9/03
157	Payment denied/reduced because service/procedure was provided as a result of an act of war.	New as of 9/03
158	Payment denied/reduced because service/procedure was provided outside of the United States.	New as of 9/03
159	Payment denied/reduced because service/procedure was provided as a result of terrorism.	New as of 9/03
160	Payment denied/reduced because injury/illness was the result of an activity that is a benefit exclusion.	New as of 9/03
113	Payment denied/reduced because service/procedure was provided outside the United States or as a result of war.	Inactive for version 4060. Use codes 15, 158 or 159
A2	Contractual Adjustment	Inactive for version 4060. Use code 45 with Group Code "CO" or use another appropriate specific adjustment code.

B. Policy: The version 4010A1 of X12N transactions as presented in the X12N Implementation Guides (IGs) have been adopted as the standard transactions by the HHS secretary. Medicare policy is to follow the IGs to be HIPAA compliant. For transaction 835 (Health Care Claim Payment/Advice), there are two code sets – reason and remark code sets – that must be used, and these code sets are updated on a regular basis. Medicare contractors must use only valid codes, and make the necessary changes on a regular basis.

C. Provider Education: Fiscal Intermediaries (FIs), carriers, and DMERCs shall inform affected providers by posting either a summary or relevant portions of this document on their Web site within two – three weeks of the issuance date. Also, FIs, carriers, and DMERCs shall publish this same information in their next regularly scheduled bulletin. If they have a listserv

that targets affected providers, they shall use it to notify subscribers that information about reason and remark code update is available on their Web site.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement #	Requirements	Responsibility
3122.1	Intermediaries/Carriers/DMERCs and VMS shall replace retired and modified remark and reason codes that are applicable to Medicare by April 1, 2004.	Intermediaries/ Carriers/ DMERCs/VMS
3122.2	Intermediaries/Carriers/DMERCs, and VMS shall add new remark and reason codes that are applicable to Medicare by April 1, 2004.	Intermediaries/ Carriers/ DMERCs/VMS
3122.3	Intermediaries/Carriers/DMERCs shall furnish provider education about changes in remittance advice codes. Intermediaries/Carriers/DMERCs shall inform affected provider communities by posting relevant portions of this instruction on their websites within 2-3 weeks of the issuance date on this instruction. In addition, this same information shall be published in your next regularly scheduled bulletin. If you have a listserv that targets the affected provider communities, you shall use it to notify subscribers that information about the Remittance Advice Remark and Reason Code Update is available on your website.	Intermediaries/ Carriers/ DMERCs

III. SUPPORTING INFORMATION & POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: April 1, 2004 **Implementation Date: April 5, 2004** **Pre-Implementation Contact(s):** **Sumita Sen, ssen@cms.hhs.gov** **410-786-5755** **Post-Implementation Contact(s):** **Sumita Sen, ssen@cms.hhs.gov** **410-786-5755**	**These instructions shall be implemented within your current operating budget**