Program Memorandum
Intermediaries/Carriers

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

Transmittal AB-03-012 **Date: FEBRUARY 3, 2003**

CHANGE REQUEST 2546

SUBJECT: Remittance Advice Remark and Reason Code Update

This Program Memorandum (PM) updates remark and reason codes for intermediaries, carriers and Durable Medical Equipment Regional Contractors (DMERCs).

X12N 835 Health Care Remittance Advice Remark Codes

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 4010 Implementation Guide (IG). Under the Insurance Portability and Accountability Act (HIPAA), all payers have to use reason and remark codes approved by X-12 recognized maintainers instead of proprietary codes to explain any adjustment in the payment. As a result, CMS received a significant number of requests for new remark codes and modifications in existing remark codes from non-Medicare entities. 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 in the form of a PM or manual instruction implementing the policy change, in addition to the regular code update PM. The code changes initiated by Medicare have been identified in this PM to single out codes that must be implemented by the contractors and the Shared System maintainers.

The list of remark codes is available at http://www.cms.hhs.gov/providers/edi/hipaadoc.asp and http://www.wpc-edi.com/hipaa/, and the list is updated each March, July, and November. By April 1, 2003, you must have completed entry of all applicable code changes and new codes for use in production, and continue downloading from one of the above mentioned web sites every 4 months to make sure that all Medicare carriers, intermediaries, and DMERCs are using the latest approved remark codes as included in any CMS instructions in their 835 version 4010 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). Contractor and shared system changes must be made, as necessary, as part of a routine release to reflect changes such as retirement of previously used codes or newly created codes that may impact Medicare.

The following list summarizes changes made through October 31, 2002.

New Remark Codes

Code	Current Narrative	Medicare Initiated
N117	This service is paid only once in a lifetime per beneficiary.	**Y**
N118	This service is not paid if billed more than once every 28 days.	**Y**

Code	Current Narrative	Medicare Initiated
N119	This service is not paid if billed once every 28 days, and the patient has spent 5 or more consecutive days in any inpatient or SNF (Part B) facility within those 28 days.	**Y**
N120	Payment is subject to home health prospective payment system partial episode payment adjustment. Beneficiary transferred or was discharged/readmitted during payment episode.	**Y**
N121	Medicare Part B does not pay for items or services provided by this type of practitioner for beneficiaries in a Medicare Part A covered skilled nursing facility stay.	**Y**
N122	Mammography add-on code can not be billed by itself.	**Y**
N123	This is a split service and represents a portion of the units from the originally submitted service.	**Y**
N124	Payment has been denied for the/made only for a less extensive service/item because the information furnished does not substantiate the need for the (more extensive) service/item. The patient is liable for the charges for this service/item as you informed the patient in writing before the service/item was furnished that we would not pay for it, and the patient agreed to pay.	**Y**
N125	Payment has been (denied for the/made only for a less extensive) service/item because the information furnished does not substantiate the need for the (more extensive) service/item. If you have collected any amount from the patient, you must refund that amount to the patient within 30 days of receiving this notice. The law permits exceptions to this refund requirement in two cases: • If you did not know, and could not have reasonably been expected to know, that Medicare would not pay for this service/item; or • If you notified the beneficiary in writing before providing it that Medicare likely would deny the service/item, and the beneficiary signed a statement agreeing to pay.	**Y**

Code	Current Narrative	Medicare Initiated
	If an exception applies to you, or you believe the carrier was wrong in denying payment, you should request review of this determination by the carrier within 30 days of receiving this notice. Your request for review should include any additional information necessary to support your position. If you request review within 30 days, you may delay refunding to the beneficiary until you receive the results of the review. If the review determination is favorable to you, you do not have to make any refund. If the review is unfavorable, you must make the refund within 15 days of receiving the unfavorable review decision. You may request review of the determination at any time within 120 days of receiving this notice. A review requested after the 30-day period does not permit you to delay making the refund. Regardless of when a review is requested, the patient will be notified that you have requested one, and will receive a copy of the determination. The patient has received a separate notice of this denial decision. The notice advises that he or she may be entitled to a refund of any amounts paid, if you should have known that Medicare would not pay and did not tell him or her. It also instructs the patient to contact your office if he or she does not hear anything about a refund within 30 days. The requirements for refund are in §1834(a)(18) of the Social Security Act (and in §§1834(j)(4) and 1879(h) by cross-reference to §1834(a)(18)). Section 1834(a)(18)(B) specifies that suppliers which knowingly and willfully fail to make appropriate refunds may be subject to civil money penalties and/or exclusion from the Medicare program. If you have any questions about this notice, please contact this office.	
N126	Social Security Records indicate that this individual has been deported. This payer does not cover items and services furnished to individuals who have been deported.	**Y**

Code	Current Narrative	Medicare Initiated
N127	This is a misdirected claim/service for a United Mine Workers of America beneficiary. Submit paper claims to: UMWA Health and Retirement Funds, PO Box 389, Ephraim, UT 84627-0361. Call Envoy at 1-800-215-4730 for information on electronic claims submission.	**Y**
N128	This amount represents the prior to coverage portion of the allowance.	
N129	This amount represents the dollar amount not eligible due to the patient's age.	
N130	Consult plan benefit documents for information about Restrictions for this service.	
N131	Total payments under multiple contracts cannot exceed the allowance for this service.	
N132	Payments will cease for services rendered by this US Government debarred or excluded provider after the 30 day grace period as previously notified.	
N133	Services for predetermination and services requesting payment are being processed separately.	
N134	This represents your scheduled payment for this service. If treatment has been discontinued, please contact Customer Service.	
N135	Record fees are the patient's responsibility and limited to the specified co-payment.	
N136	To obtain information on the process to file an Appeal in Arizona, call the Department's Consumer Assistance Office at (602) 912-8444 or (800) 325-2548.	

Code	Current Narrative	Medicare Initiated
N137	You, the provider, acting on the Member's behalf, may file an appeal with our Company. You, the provider, acting on the Member's behalf, may file a complaint with the Commissioner in the state of Maryland without first first filing an appeal, if the coverage decision involves an urgent condition for which care has not been rendered. The Commissioner's address: Commissioner Steven B. Larsen, Maryland Insurance Administration, 525 St. Paul Place, Baltimore, MD 21202 - (410) 468-2000.	
N138	In the event you disagree with the Dental Advisor's opinion and have additional information relative to the case, you may submit radiographs to the Dental Advisor Unit at the subscriber's dental insurance carrier for a second Independent Dental Advisor Review.	
N139	Under the Code of Federal Regulations, Chapter 32, Section 199.13 a non-participating provider is not an appropriate appealing party. Therefore, if you disagree with the Dental Advisor's opinion, you may appeal the determination if appointed in writing, by the beneficiary, to act as his/her representative. Should you be appointed as a representative, submit a copy of this letter, a signed statement explaining the matter in which you disagree, and any radiographs and relevant information to the subscriber's Dental insurance carrier within 90 days from the date of this letter.	
N140	You have not been designated as an authorized OCONUS provider, therefore, are not considered an appropriate appealing party. If the beneficiary has appointed you, in writing, to act as his/her representative and you disagree with the Dental Advisor's opinion, you may appeal by	

Code	Current Narrative	Medicare Initiated
	submitting a copy of this letter, a signed statement explaining the matter in which you disagree, and any relevant information to the subscriber's Dental insurance carrier within 90 days from the date of this letter.	
N141	The patient was not residing in a long-term care facility during all or part of the service dates billed.	
N142	The original claim was denied. Resubmit a new claim, not a replacement claim.	
N143	The patient was not in a hospice program during all or part of the service dates billed.	
N144	The rate changed during the dates of service billed.	
N145	Missing/incomplete/invalid provider identifier for this place of service.	
N146	Missing/incomplete/invalid/not approved screening document.	
N147	Long term care case mix or per diem rate cannot be determined because the patient ID number is missing, incomplete, or invalid on the assignment request.	
N148	Missing/incomplete/invalid date of last menstrual period.	
N149	Rebill all applicable services on a single claim.	
N150	Missing/incomplete/invalid model number.	
N151	Telephone contact services will not be paid until the face-to-face contact requirement has been met.	
N152	Missing/incomplete/invalid replacement claim information.	
N153	Missing/incomplete/invalid room and board rate.	

Code	Current Narrative	Medicare Initiated
N154	This payment was delayed for correction of provider's mailing address.	
N155	Our records do not indicate that other insurance is on file. Please submit other insurance information for our records.	
N156	The patient is responsible for the difference between the approved treatment and the elective treatment.	

Modified Remark Codes

M25	Payment has been (denied for the/made only for a less extensive) service because the information furnished does not substantiate the need for the (more extensive) service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this (more extensive) service, or if you notified the patient in writing in advance that we would not pay for this (more extensive) service and he/she agreed in writing to pay, ask us to review your claim within 120 days of the date of this notice. If you do not request a review, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her (for the/in excess of any deductible and coinsurance amounts applicable to the less extensive) service. We will recover the reimbursement from you as an overpayment.	**Y**
M26	Payment has been (denied for the/made only for a less extensive) service because the information furnished does not substantiate the need for the (more extensive) service. If you have collected (any amount from the patient/any amount that exceeds the limiting charge for the	**Y**

Code	Current Narrative	Medicare Initiated

less extensive service), the law requires you to refund that amount to the patient within 30 days of receiving this notice.

The law permits exceptions to the refund requirement in two cases:

- If you did not know, and could not have reasonably been expected to know, that we would not pay for this service; or
- If you notified the patient in writing before providing the service that you believed that we were likely to deny the service, and the patient signed a statement agreeing to pay for the service.

If you come within either exception, or if you believe the carrier was wrong in its determination that we do not pay for this service, you should request review of this determination within 30 days of the date of this notice. Your request for review should include any additional information necessary to support your position.

If you request review within 30 days of receiving this notice, you may delay refunding the amount to the patient until you receive the results of the review. If the review decision is favorable to you, you do not need to make any refund. If, however, the review is unfavorable, the law specifies that you must make the refund within 15 days of receiving the unfavorable review decision.

The law also permits you to request review at any time within 120 days of the date of this notice. However, a review request that is received more than 30 days after the date of this notice, does not permit you to delay making the refund. Regardless of when a review is requested, the patient will be notified that you have requested one, and will receive a copy of the determination.

Code	Current Narrative	Medicare Initiated
	The patient has received a separate notice of this denial decision. The notice advises that he/she may be entitled to a refund of any amounts paid, if you should have known that we would not pay and did not tell him/her. It also instructs the patient to contact your office if he/she does not hear anything about a refund within 30 days. The requirements for refund are in 1842(l) of the Social Security Act and 42CFR411.408. The section specifies that physicians who knowingly and willfully fail to make appropriate refunds may be subject to civil monetary penalties and/or exclusion from the program. Please contact this office if you have any questions about this notice.	
M27	The patient has been relieved of liability of payment of these items and services under the limitation of liability provision of the law. You, the provider, are ultimately liable for the patient's waived charges, including any charges for coinsurance, since the items or services were not reasonable and necessary or constituted custodial care, and you knew or could reasonably have been expected to know, that they were not covered. You may appeal this determination provided that the patient does not exercise his/her appeal rights. If the beneficiary appeals the initial determination, you are automatically made a party to the appeals determination. If, however, the patient or his/her representative has stated in writing that he/she does not intend to request a reconsideration, or the patient's liability was entirely waived in the initial determination, you may initiate an appeal.	**Y**

Code	Current Narrative	Medicare Initiated
	You may ask for a reconsideration for hospital insurance (or a review for medical insurance) regarding both the coverage determination and the issue of whether you exercised due care. The request for reconsideration must be filed within 120 days of the date of this notice (or, for a medical insurance review, within 120 days of the date of this notice). You may make the request through any Social Security office or through this office.	
M80	Not covered when performed during the same session/date as a previously processed service for the patient.	
MA01	(Initial Part B determination, Medicare carrier or intermediary) If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the review. However, in order to be eligible for a review, you must write to us within 120 days of the date of this notice, unless you have a good reason for being late. An institutional provider, e.g., hospital, SNF, HHA or hospice may appeal only if the claim involves a reasonable and necessary denial, a SNF recertified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, or a hospice care denial because the patient was not terminally ill, and either the patient or the provider is liable under Section 1879 of the Social Security Act, and the patient chooses not to appeal. If your carrier issues telephone review decisions, a professional provider should phone the carrier's office for a telephone review if the criteria for a telephone review are met.	**Y**

Code	Current Narrative	Medicare Initiated
MA02	(Initial Medicare Part A determination) If you do not agree with this determination, you have the right to appeal. You must file a written request for reconsideration within 120 days of the date of this notice. Decisions made by a Quality Improvement Organization (QIO) must be appealed to that QIO within 60 days. An institutional provider, e.g., hospital, SNF, HHA or a hospice may appeal only if the claim involves a reasonable and necessary denial, a SNF non-certified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, or a hospice care denial because the patient was not terminally ill, and either the patient or the provider is liable under Section1879 of the Social Security Act, and the patient chooses not to appeal.	**Y**
MA03	(Medicare Hearing)--If you do not agree with the approved amounts and $100 or more is in dispute (less deductible and coinsurance), you may ask for a hearing. You must request a hearing within 6 months of the date of this notice. To meet the $100, you may combine amounts on other claims that have been denied. This includes reopened reviews if you received a revised decision. You must appeal each claim on time. At the hearing, you may present any new evidence which could affect our decision. An institutional provider, e.g., hospital, SNF, HHA or a hospice may appeal only if the claim involves a reasonable and necessary denial, a SNF noncertified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, or a hospice care denial because the patient was not terminally ill, and either the patient or the provider is liable under Section1879 of the Social Security Act, and the patient chooses not to appeal	**Y**

Code	Current Narrative	Medicare Initiated
N22	This procedure code was changed because it more accurately describes the services rendered.	**Y**
N104	This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS website at www.cms.hhs.gov	**Y**

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/hipaa/. All reason code changes from July 2002 to October 2002, are listed here. By April 1, 2003, you must have the most current reason code set installed for production, and continue downloading from the above mentioned web site every 4 months to make sure that all Medicare carriers, intermediaries, and DMERCs are using the latest approved reason codes in 835 and standard paper remittance advice transactions.

In most cases, reason code additions, modifications and retirements are requested by non-Medicare entities, Medicare may occasionally request changes. If the request comes from Medicare, it may be included in a Medicare instruction in addition to the regular code update PM. Code changes requested by entities other than Medicare would not be routinely included in a Medicare instruction as part of a policy change, but modification or retirement of an existing code could impact Medicare. A PM will be issued on a periodic basis to provide a summary of changes in the reason and remark codes introduced since the last update PM, and will establish the deadline for Medicare contractors to implement the reason and remark code changes applicable to Medicare 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 also can discontinue use of retired codes in prior versions. Contractors and shared system maintainers must modify their maps or programming as necessary by the date the specified electronic version or a higher numbered version is implemented, or earlier if the replacing code is available for the earlier version(s), if a retired code is being used.

The committee approved the following reason code changes in October 2002:

New Reason Codes

Code	Current Narrative	Medicare Initiated
149	Lifetime benefit maximum has been reached for this service/benefit category.	
150	Payment adjusted because the payer deems the information submitted does not support this level of service.	**Y**
151	Payment adjusted because the payer deems the information submitted does not support this many services.	**Y**
152	Payment adjusted because the payer deems the information submitted does not support this length of service.	**Y**
153	Payment adjusted because the payer deems the information submitted does not support this dosage.	**Y**
154	Payment adjusted because the payer deems the information submitted does not support this day's supply.	**Y**

Modified Reason Codes

35	Lifetime benefit maximum has been reached	

Retired Reason Codes

57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply. (Inactive for version 4050)	**Y**
88	Adjustment amount represents collection against receivable created in prior overpayment**.** (Inactive for version 4050)	

Implementation of Reason and Remark Codes

As instructed before, shared system maintainers must provide a crosswalk between the reason and remark codes to the shared system internal codes so that a carrier or DMERC or intermediary can

easily locate and update each internal code that may be impacted by a remittance advice reason/remark code change to eliminate the need for lengthy and error prone manual carrier/DMERC/intermediary searches to identify each affected internal code.

The effective date of programming for use of new or modified reason/remark codes applicable to Medicare is the earlier of the date specified in the contractor manual transmittal or PM requiring implementation of a policy change that led to the issuance of the new/modified code, or the date specified in the periodic PM announcing issuance of the code changes. Contractors must notify providers of the new and/or modified codes and their meanings in a provider bulletin or other instructional release prior to issuance of the remittance advice transactions that include these changes.

Medicare contractors must use appropriate remark codes in conjunction with the appropriate reason code(s) when applicable, and must make sure that they are using the currently valid reason and remark codes.

Provider Education

Contractors must notify providers of the new and/or modified codes and their meanings in their next scheduled provider bulletin or other instructional release prior to issuance of remittance advice transactions that include these changes. Contractors must place this information on their web sites within the next 2 weeks.

The effective date for this Program Memorandum (PM) is April 1, 2003.

The implementation date for this PM is April 1, 2003.

These instructions should be implemented within your current operating budget.

This PM may be discarded after April 1, 2004.

If you have any questions, contact Sumita Sen at 410-786-5755 or ssen@cms.hhs.gov.