CMS Manual System

Pub. 100-04 Medicare Claims Processing

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

Transmittal 609 **Date: JULY 22, 2005**

CHANGE REQUEST 3923

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

I. SUMMARY OF CHANGES: This Recurring Update Notification contains information about reason and remark code changes approved from November 2004 through February 2005. Medicare contractors must update their remittance advice maps/matrices as appropriate to incorporate those changes that impact their electronic and paper remittance advice, and coordination of benefits transactions.

NEW/REVISED MATERIAL - EFFECTIVE DATE*: October 1, 2005
IMPLEMENTATION DATE: October 3, 2005

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. 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 not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)

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

III. FUNDING:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2005 budgets.

IV. ATTACHMENTS:

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

***Unless otherwise specified, the effective date is the date of service.**

Attachment – Recurring Update Notification

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

I. GENERAL INFORMATION

A. Background: Per the 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 using valid standard codes. Claim Adjustment Reason Codes (CARC) are required to be used in remittance advice and coordination of benefits transactions, and Remittance Advice Remark Codes (RARC) are required to be used in remittance advice transaction.

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 the ASC X12 transaction 835 (Health Care Claim Payment/Advice) version 4010A1 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 payment. As the X12 recognized maintainer of the RARC, CMS receives a significant number of requests for new remark codes and modifications in existing remark codes from Medicare and non-Medicare entities. Additions and modifications to the code list resulting from non-Medicare requests 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

(**NOTE**: If you find any discrepancy between any code text included in this Change Request and the corresponding text as posted on the Washington Publishing Company (WPC) Web site, use the text posted at the WPC Web site.)

The list is updated 3 times a year. By October 3, 2005, you must have completed entry of all applicable code text changes and new codes, and terminated use of deactivated codes. You must use the latest approved and valid codes in your 835, corresponding standard paper remittance advice, and coordination

of benefits transactions. The following list summarizes changes made from November 1, 2004, to February 28, 2005.

New Code	Current Narrative	Medicare Initiated
N345	Date range not valid with units submitted.	N
N346	Missing/incomplete/invalid oral cavity designation code.	N
N347	Your claim for a referred or purchased service cannot be paid because payment has already been made for this same service to another provider by a payment contractor representing the payer.	Y

Modified Remark Codes

Code	Current Modified Narrative	Modification Date
MA100	Missing/incomplete/invalid date of current illness or symptoms.	Modified eff. 3/30/05
MA128	Missing/incomplete/invalid FDA approval number.	Modified eff.3/30/05

Deactivated Remark Codes

None

X12 N 835 Health Care Claim Adjustment Reason Codes

A national 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. Select Claim Adjustment Reason Codes from the pull down menu. All reason code changes approved in February 2005 are listed here. By October 3, 2005, you must have completed entry of all applicable code text changes and new codes, and terminated use of deactivated codes. You must use the latest approved and valid codes in your 835, corresponding standard paper remittance advice, and coordination of benefits 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 Washington Publishing Company (WPC) posting. The committee approved the following reason code changes in February 2005.

Reason Code Changes

Code	Current Narrative	Notes
166	These services were submitted after this payers responsibility for processing claims under this plan ended.	New as of 2/05

There was no retirement. There were some typos identified in codes 52, 57, 70, 76 and 146, and corrected.

B. Policy: For transactions 835 (Health Care Claim Payment/Advice), 837 COB, and standard paper remittance advice, there are two code sets – reason and remark code sets – that must be used to report payment adjustments, appeal rights, and related information. These code sets are updated on a regular basis. Medicare contractors must use only currently valid codes, and 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.

C. MedLearn Matters provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "MedLearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article must be included in your next regularly scheduled bulletin. Contractors are free to supplement MedLearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.

II. BUSINESS REQUIREMENTS

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

		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
						FISS	MCS	VMS	CWF	

		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
						FISS	MCS	VMS	CWF	
3923.1	Intermediaries/RHHIs/Carriers/DMERCs and VMS shall update reason and remark codes that have been modified and which apply to Medicare by October 3, 2005.	X	X	X	X			X		
3923.2	Intermediaries/RHHIs/Carriers/DMERCs, and VMS shall add new reason and remark codes that are applicable to Medicare by October 3, 2005	X	X	X	X			X		
3923.3	Intermediaries/RHHIs/Carriers/DMERCs shall furnish provider education about changes in claim adjustment reason and remittance advice remark codes. Contractors shall post the above mentioned MedLearn article, or a direct link to the article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article must be included in your next regularly scheduled bulletin.	X	X	X	X					

III. SUPPORTING INFORMATION AND 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*: October 1, 2005 **Implementation Date: October 3, 2005** **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	**Medicare contractors shall implement these instructions within their current operating budgets.**

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