CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2213	Date: May 6, 2011
	Change Request 7369

Transmittal 2194, dated April 22, 2011, is being rescinded and replaced by Transmittal 2213 to replace "variation" with "verification" for Code N542 in the table under New codes - RARC and delete Code N129 from the table under Modified Codes - RARC. All other information remains the same.

SUBJECT: Claim Adjustment Reason Code (CARC), Remittance Advice Remark Code (RARC), and Medicare Remit Easy Print (MREP) Update

I. SUMMARY OF CHANGES: This Change Request (CR) instructs the contractors to update Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) reported on the Remittance Advice (RA). It also instructs VMS to update Medicare Remit Easy Print (MREP) software. This Recurring Update applies to chapter 22, sections 60.1 and 60.2 of the Medicare Claims Processing Manual.

EFFECTIVE DATE: July 1, 2011
IMPLEMENTATION DATE: July 5, 2011

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. 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 is not updated)
R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	22/60/60.1/Claim Adjustment Reason Codes
R	22/60/60.2/Remittance Advice Remark Codes

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Manual Instruction

Recurring Update Notification

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

Attachment – Recurring Update Notification

Pub. 100-04	Transmittal: 2213	Date: May 6, 2011	Change Request: 7369

Transmittal 2194, dated April 22, 2011, is being rescinded and replaced by Transmittal 2213 to replace "variation" with "verification" for Code N542 in the table under New codes - RARC and delete Code N129 from the table under Modified Codes - RARC. All other information remains the same.

SUBJECT: Claim Adjustment Reason Code (CARC), Remittance Advice Remark Code (RARC), and Medicare Remit Easy Print (MREP) Update

Effective Date: July 1, 2011
Implementation Date: July 5, 2011

I. GENERAL INFORMATION

A. 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. Medicare policy states that Claim Adjustment Reason Codes (CARCs) are required in the remittance advice and coordination of benefits transactions. Medicare policy further states that appropriate Remittance Advice Remark Codes (RARCs) that provide either supplemental explanation for a monetary adjustment or policy information that generally applies to the monetary adjustment are required in the remittance advice transaction.

The CARC and RARC changes that impact Medicare are usually requested by CMS staff in conjunction with a policy change. Contractors and Shared System Maintainers (SSMs) are notified about these changes in the corresponding instructions from the specific CMS component that implements the policy change, in addition to the regular code update notification. If a modification has been initiated by an entity other than CMS for a code currently used by Medicare, contractors must either use the modified code or another code if the modification makes the modified code inappropriate to explain the specific reason for adjustment. **SSMs have the responsibility to implement code deactivation making sure that any deactivated code is not used in original business messages, but the deactivated code in derivative messages is allowed. SSMs must make sure that Medicare does not report any deactivated code on or before the effective date for deactivation as posted on the WPC Web site.** Contractors shall stop using codes that have been deactivated on or **before** the effective date specified in the comment section (as posted on the WPC Web site) if they are currently being used. In order to comply with any deactivation, Medicare may have to stop using the deactivated code in original business messages **before** the actual "Stop Date" posted on the WPC Web site because the code list is updated three times a year and may not align with the Medicare release schedule. Note that a deactivated code used in derivative messages must be accepted even after the code is deactivated if the deactivated code was used before the deactivation date by a payer who adjudicated the claim before Medicare. Medicare contractors must stop using any deactivated reason and/or remark code past the deactivation date whether the deactivation is requested by Medicare or any other entity. **The regular code update Change Request (CR) will establish the implementation date for all modifications, deactivations, and any new code for Medicare contractors and the SSMs. If another specific CR has been issued by another CMS component with a different implementation**

date, the earlier of the two dates will apply for Medicare implementation. This recurring CR lists only the changes that have been approved since the last code update CR (CR 7250 Transmittal 2131), and does not provide a complete list of codes in these two code sets. You must get the complete list for both CARC and RARC from the WPC Web site that is updated three times a year – around March 1, July 1, and November 1 – to get the comprehensive lists for both code sets, but the implementation date for any new or modified or deactivated code for Medicare contractors is established by this recurring code update CR published three or four times a year according to the Medicare release schedule (see above for exception).

WPC Web site address: **http://www.wpc-edi.com/Codes**

The WPC Web site has four listings available for both CARC and RARC:

All: All codes including deactivated and to be deactivated codes are included in this listing.
To Be Deactivated: Only codes to be deactivated at a future date are included in this listing.
Deactivated: Only codes with prior deactivation effective date are included in this listing.
Current: Only currently valid codes are included in this listing.

NOTE I: In case of any discrepancy in the code text as posted on WPC Web site and as reported in any CR, the WPC version should be implemented.

NOTE II: This recurring Code Update CR lists only the changes approved since the last recurring Code Update CR **once.** If any modification becomes effective at a future date, contractors must make sure that they update on the quarterly release date that matches the effective date as posted on the WPC Web site.

Claim Adjustment Reason Code (CARC):

A national code maintenance committee maintains the health care Claim Adjustment Reason Codes (CARCs). The Committee meets at the beginning of each X12 trimester meeting (January/February, June and September/October) and makes decisions about additions, modifications, and retirement of existing reason codes. The updated list is posted three times a year around early March, July, and November. To access the list go to: **http://www wpc-edi.com/Codes**

The new codes usually become effective when approved unless mentioned otherwise. Any modification or deactivation becomes effective on the next quarterly release date (April 1 or July 1 or October 1 or January 1) or later to provide lead time for implementing necessary programming changes. Exception: The effective date for a modification may be as early as the approval or publication date if the requester can provide enough justification to have the modification become effective earlier than the next quarterly release date. A health plan may decide to implement a code deactivation before the actual effective date posted on WPC Web site as long as the deactivated code is allowed to come in on Coordination of Benefits (COB) claims if the previous payer(s) has (have) used that code prior to the deactivation date. In most cases Medicare will stop using a deactivated code before the deactivation becomes effective per the WPC Web site to accommodate the Medicare release schedule.

The following new Claim Adjustment Reason Codes were approved by the Code Committee in January, and must be implemented, if appropriate, by July 5, 2011.

New Codes – CARC:

Code	Current Narrative	Effective Date per WPC Posting
236	This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative.	1/30/2011

Modified Codes – CARC:

None

Deactivated Codes – CARC:

None

Remittance Advice Remark Codes (RARC):

CMS is the national maintainer of the remittance advice remark code list. This code list is used by reference in the ASC X12 N transaction 835 (Health Care Claim Payment/Advice) version 004010A1 and 005010A1 Implementation Guide (IG)/Technical Report (TR) 3. 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 claim payment. CMS as the X12 recognized maintainer of RARCs receives requests from Medicare and non- Medicare entities for new codes and modification/deactivation of existing codes. Additions, deletions, and modifications to the code list resulting from non-Medicare requests may or may not impact Medicare. Remark and reason code changes that impact Medicare are usually requested by CMS staff in conjunction with a policy change. Contractors are notified about these changes in the corresponding instructions from the specific CMS component which implements the policy change, in addition to the regular code update notification. If a modification has been initiated by an entity other than CMS for a code currently used by Medicare, contractors must use the modified code even though the modification was not initiated by Medicare. Shared System Maintainers have the responsibility to implement code (both CARC and RARC) deactivation making sure that any deactivated code is not used in original business messages, but the deactivated code in derivative messages is allowed. **Contractors must stop using codes that have been deactivated on or before the effective date specified in the comment section (as posted on the WPC Web site) if they are currently being used. Medicare contractors are not to use any deactivated reason and/or remark code past the deactivation date whether the deactivation is requested by Medicare or any other entity.** The complete list of remark codes is available at: **http://www.wpc-edi.com/Codes.**

RARC list is updated three times a year – in early March, July and November although the RARC Committee meets every month. The RARC Committee has established the following schedule:
Request received in October – January:
Published in early March.
Deactivation becomes effective in October
Any new code or modification become effective when published

Request received in February – May:
Published in early July
Deactivation becomes effective in January
Any new code or modification become effective when published

Request received in June – September:
Published in early November
Deactivation becomes effective in July
Any new code or any modification becomes effective when published

NOTE: Exception to the above schedule may be approved by the RARC Committee if enough justification is provided by the requester.

This recurring CR is published four times a year. Codes are updated three times a year, April, July and October as part of this recurring CR. The fourth publication in January is usually used to address MREP enhancement requests.

As mentioned earlier, specific CMS components may publish CRs in addition to the recurring code update CRs instructing contractors to use specific CARCs/ RARCs and establishing an implementation date that may differ from the implementation date mentioned in the recurring code update CR. If there is any difference in the implementation dates, the contractors are to implement on the earlier of the two dates.

By July 5, 2011, contractors must complete entry of all applicable code text changes and new codes, and the SSMs shall implement all code deactivations. Contractors must use the latest approved and valid Remittance Advice Remark codes in the 835 and corresponding Standard Paper Remittance (SPR) advice.

NOTE: Some remark codes may only provide general information that may not necessarily supplement the specific explanation provided through a reason code and in some cases another/other remark code(s) for a monetary adjustment. Codes that are "Informational" will have the word "Alert" in the text to identify them as informational rather than explanatory codes. These "Informational" codes may be used without any specific monetary adjustment and an associated CARC explaining the monetary adjustment. **These informational codes should be used only if specific information about adjudication (like appeal rights) needs to be communicated but not as default codes when a RARC is required with a CARC e.g., 16, 96, 125, 129, 148, 226, 227, 234, A1, and D23.**

New Codes – RARC:

Code	Current Narrative	Medicare Initiated
N542	Missing income verification	No
N543	Incomplete/invalid income verification	No

Modified Codes – RARC:

Code	Modified Narrative	Medicare Initiated
M37	Not covered when the patient is under age 35.	No
M116	Processed under a demonstration project or program. Project or program is ending and	No

	additional services may not be paid under this project or program.	
N62	Dates of service span multiple rate periods. Resubmit separate claims.	No
N356	Not covered when performed with, or subsequent to, a non-covered service.	No
N383	Not covered when deemed cosmetic.	No
N410	Not covered unless the prescription changes.	No
N428	Not covered when performed in this place of service.	No
N429	Not covered when considered routine.	No
N431	Not covered with this procedure.	No

Deactivated Codes – RARC:

None

B. Policy: For transaction 835 (Health Care Claim Payment/Advice) and standard paper remittance advice, there are two code sets – Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) – that must be used to report payment adjustments, appeal rights, and related information. Additionally, for transaction 837 COB, CARC must be used. These code sets are updated three times a year on a regular basis. Medicare contractors must report only currently valid codes in both the remittance advice and COB Claim transaction, and must allow deactivated CARC and RARC in derivative messages when certain conditions are met (see Business Requirements segment for explanation of conditions). Shared System Maintainers and contractors must make the necessary changes on a regular basis as per this recurring code update CR and/or the specific CR that describes the change in policy that resulted in the code change requested by Medicare. Any modification and/or deactivation will be implemented by Medicare even when the modification and/or the deactivation has not been initiated by Medicare.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7369.1	Contractors shall update reason and remark codes that have been modified and apply to Medicare by July 5, 2011. **Note:** Some modifications may become effective at a future date. Contractors shall make sure that modifications are implemented **on the effective date as**	X	X	X	X	X					

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	posted on the WPC Web site (which may be later than the implementation date mentioned in this CR) for those code modifications that are being used by Medicare.										
7369.2	Contractors shall update reason and remark codes to include new codes that apply to Medicare by July 5, 2011 or after July 5, 2011 if instructed by CMS.	X	X	X	X	X					
7369.3	FISS, MCS, and VMS shall make necessary programming changes so that no deactivated reason and remark code is reported in the remittance advice and no deactivated reason code is reported in the COB claim by July 5, 2011.						X	X	X		
7369.4	FISS, MCS, VMS shall update any crosswalk between the standard reason and remark codes and the shared system internal codes provided to the contractors and make any deactivated standard code unavailable for use by the contractor by July 5, 2011.						X	X	X		
7369.5	FISS, MCS, CEDI shall make necessary programming changes so that deactivated reason and remark codes are allowed in derivative messages after the deactivation implementation date per this CR or as posted on the WPC Web site when: • Medicare is not primary; • The COB claims is received after the deactivation effective date; and • The date in DTP03 in Loop 2430 or 2330B in COB 837 transaction is less than the deactivation effective date as posted on the WPC Web site.						X	X			CEDI
7369.6	FISS, MCS, and VMS shall make necessary programming changes so that deactivated reason and remark codes are allowed even after the deactivation implementation date in a Reversal and Correction situation when a value of 22 in CLP02 identifies the claim to be a corrected claim.						X	X	X		
7369.7	VMS shall update the Medicare Remit Easy Print (MREP) software by July 5, 2011. This update shall be based on the CARC and RARC lists as posted on WPC Web site on March 8, 2011. **Note**: This update is provided in a separate file since April, 2008.								X		
7369.8	A/B MACs, carriers, and CEDI for DME MACs shall	X			X						CEDI

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	notify the users that the code update file must be downloaded to be used in conjunction with the updated MREP software.										

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7369.9	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN 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 one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X	X						CEDI

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:

X-Ref Requirement Number	Recommendations or other supporting information:
	N/A

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Sumita Sen at sumita.sen@cms.hhs.gov or 410-786-5755
Pre-Implementation Contact(s): Angie Bartlett at angie.bartlett@cms.hhs.gov or 410-786-2865

Post-Implementation Contact(s): Contact your Contracting Officer's Technical Representative (COTR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs)*:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

60.1 - Claim Adjustment Reason Codes

(Rev. 2213, Issued: 05-06-11, Effective: 07-01-11, Implementation: 07-05-11)

Claim Adjustment Reason Codes (CARCs) are used on the Medicare electronic and paper remittance advice, and Coordination of Benefit (COB) claim transaction. The Claim Adjustment Status Code Maintenance Committee maintains this code set. A new code may not be added and the indicated wording may not be modified without the approval of this committee. These codes were developed for use by all U.S. health payers. As a result, they are generic, and there are a number of codes that do not apply to Medicare. This code set is updated three times a year. Medicare contractors shall use only the most current valid codes in ERA, SPR, and COB claim transactions.

Any reference to procedures or services mentioned in the reason codes apply equally to products, drugs, supplies or equipment. References to prescriptions also include certificates of medical necessity (CMNs).

These reason codes explain the reasons for any financial adjustments, such as denials, reductions or increases in payment. These codes may be used at the service or claim level, as appropriate. Current 835 structure only allows one reason code to explain any one specific adjustment amount.

There are basic criteria that the Claim Adjustment Status Code Maintenance Committee considers when evaluating requests for new codes:

- Can the information be conveyed by the use or modification of an existing reason code?
- Is the information available elsewhere in the 835?
- Will the addition of the new reason code make any significant difference in the action taken by the provider who receives the message?

The list of Claim Adjustment Reason Codes can be found at:
http://www.wpc-edi.com/codes

The updated list is published three times a year after the committee meets before the ANSI ASC X12 trimester meeting in the months of January/February, June, and September/October. Medicare contractors must make sure that they are using the latest approved claim adjustment reason codes in ERA, SPR and COB transaction by implementing necessary code changes as instructed in CMS *Recurring Update Notifications or any other CMS instruction* or downloading the list after each update. The Shared System Maintainers shall make sure that a deactivated code (either reason or remark) is not allowed to be used in any original business message, but is allowed and processed when reported in derivative business messages. Code deactivation may be implemented prior to the stop date posted at the WPC Web site to follow Medicare release schedule. SSMs shall implement deactivation on the earlier date if the implementation date in the recurring code update CR is different than the stop date posted at the WPC Web site.

Contractors are responsible for entering claim adjustment reason code updates to their shared system and entry of parameters for shared system use to determine how and when particular codes are to be reported in remittance advice and coordination of benefits transactions. In most cases, reason and remark codes reported in remittance advice transactions are mapped to alternate codes used by a shared system. These shared system codes may exceed the number of the reason and remark codes approved for reporting in a remittance advice transaction. A particular 835 reason or remark code might be mapped to one or more shared system codes, or vice versa, making it difficult for a contractor to determine each of the internal codes that may be impacted by remark or reason code modification, retirement or addition.

Shared systems must provide a crosswalk between the reason and remark codes to the shared system internal codes so that a contractor 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 contractor searches to identify each affected internal code. Shared systems must also make sure that 5-position remark codes can be accommodated at both the claim and service level for 835 version 004010 onwards.

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 CMS recurring code update change request or the Medicare Claims Processing Manual transmittal that implemented a policy change that led to the issuance of the new or modified code. 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 remittance advice transactions that include these changes.

60.2 - Remittance Advice Remark Codes

(Rev. 2213, Issued: 05-06-11, Effective: 07-01-11, Implementation: 07-05-11)

Remittance Advice Remark Codes (RARC) are used in a remittance advice to further explain an adjustment or relay informational messages that cannot be expressed with a claim adjustment reason code. Remark codes are maintained by CMS, but may be used by any health plan when they apply. Medicare contractors must report any remark code(s) that apply, subject to capacity limits in the standard.

Most remark codes were initially separated into service level (line level) and claim level categories. Some of the same messages were included in both categories. To simplify remark code use, these categories have been eliminated. Any remark code may now be reported at the service or the claim level, as applicable, in any electronic or paper remittance advice version.

Remark codes that apply at the service line level must be reported in the X12N 835 LQ segment. Remark codes that apply to an entire claim must be reported in either an X12N 835 MIA (inpatient) or MOA (non-inpatient) segment, as applicable. Although the IG allows up to 5 remark codes to be reported in the MOA/MIA segment and up to 99 remark codes in the LQ segment, system limitation may restrict how many codes Medicare contractors can actually report.

The remark code list is updated three times a year, in the months following X12N trimester meetings. Medicare contractors must use the latest approved remark codes as included in the regular code *Recurring Update Notifications* or in any other CMS instructions *or downloading the list after each update* in their 835 version 004010A1 and subsequent versions, the corresponding standard paper remittance advice, and the X12N Coordination of Benefit transaction (outbound 837). 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.