Medicare Learning Network
MLN Matters®
CMS
Information for Medicare Fee-For-Service Health Care Professionals

News Flash – On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (PPACA). The Centers for Medicare & Medicaid Services (CMS) is working hard to expeditiously implement the new law. The law's Medicare fee-for-service provisions have varying effective dates and CMS' first priority is to address provisions with the earliest effective dates. CMS is committed to assuring Medicare providers are well informed as early as possible. For that reason, CMS is urging you to be on the alert for notices and instructions from CMS and from your Medicare fiscal intermediary, carrier, or Medicare Administrative Contractor, on forthcoming policy and operational changes as we implement the PPACA.

MLN Matters® Number: MM6901 Revised
Related Change Request (CR) #: 6901
Related CR Release Date: April 23, 2010
Effective Date: July 1, 2010
Related CR Transmittal #: R1950CP
Implementation Date: July 6, 2010

Note: This article was updated on November 30, 2012, to reflect current Web addresses. This article was previously revised on February 11, 2011, to add a reference to MLN Matters® article MM7218, which is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7218.pdf, to alert providers that effective July 1, 2001, the MREP software is being modified to be compatible with Microsoft Windows 7, Vista, and XP operating systems. All other information is unchanged

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

Provider Types Affected

This article is for physicians, providers, and suppliers who submit claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), Medicare Administrative Contractors (MACs), and Durable Medical Equipment Medicare Administrative Contractors (DME MACs)) for services.

Provider Action Needed

CR 6901, from which this article is taken, announces the latest update of Remittance Advice Remark Codes (RARCs) and Claim Adjustment Reason Codes (CARCs), effective July 1, 2010. Be sure billing staff are aware of these changes.

Background

The reason and remark code sets must be used to report payment adjustments in remittance advice transactions. The reason codes are also used in some coordination-of-benefits (COB) transactions. The RARC list is maintained by the Centers for Medicare & Medicaid Services (CMS), and used by all payers; and additions, deactivations, and modifications to it may be initiated by any health care organization. The RARC and CARC lists are updated 3 times a year – in March, July, and November. Both code lists are posted at *http://www.wpc-edi.com/Codes* on the Internet. The lists at the end of this article summarize the latest changes to these lists, as announced in CR 6901.

CR 6901 conveys the following updates:

New Codes - CARC

Code	Current Narrative	Effective Date Per WPC Posting
233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.	1/24/2010
234	This procedure is not paid separately. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	1/24/2010

Modified Codes - CARC

None

Deactivated Codes - CARC

None

New Codes - RARC

Code	Current Narrative	Medicare Initiated
N523	The limitation on outlier payments defined by this payer for this service period has been met. The outlier payment otherwise applicable to this claim has not been paid.	YES
N524	Based on policy this payment constitutes payment in full.	NO
N525	These services are not covered when performed within the global period of another service.	NO
N526	Not qualified for recovery based on employer size.	YES
N527	We processed this claim as the primary payer prior to receiving the recovery demand.	YES
N528	Patient is entitled to benefits for Institutional Services.	YES
N529	Patient is entitled to benefits for Professional Services.	YES
N530	Our records indicate a mismatch in enrollment information for this patient.	YES
N531	Not qualified for recovery based on direct payment of premium.	YES
N532	Not qualified for recovery based on disability and working status.	YES

Modified Codes – RARC:

Code	Modified Narrative	Medicare Initiated
N216	We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit package	NO
N522	Duplicate of a claim processed, or to be processed, as a crossover claim.	NO

Deactivated Codes – RARC

None

Additional Information

To see the official instruction (CR6901) issued to your Medicare Carrier, RHHI, DME/MAC, FI and/or MAC, refer to http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1950CP.pdf on the CMS website.

If you have questions, please contact your Medicare Carrier, RHHI, DME/MAC, FI and/or MAC at their toll-free number which may be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.