DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

News Flash – The Centers for Medicare & Medicaid Services (CMS) has launched the 2011 Medicare Contractor Provider Satisfaction Survey (MCPSS) and is waiting to hear from you. This survey offers Medicare Fee-For-Service (FFS) providers and suppliers an opportunity to provide feedback on interactions with their Medicare contractors. The survey will be sent to a random sample of approximately 30,000 Medicare FFS providers and suppliers. Those who are selected to participate will be notified starting in January. If selected to participate, please complete this important survey. To learn more about the MCPSS, please visit http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCPSS/index.html on the CMS website.

MLN Matters® Number: MM7250 Revised

Related Change Request (CR) #: 7250

Related CR Release Date: January 7, 2011

Effective Date: April 1, 2011

Related CR Transmittal #: R2131CP

Implementation Date: April 4, 2011

Note: This article was updated on August 16, 2012, to reflect current Web addresses. Previously, it was 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 service provided to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 7250, from which this article is taken, announces the latest update of Remittance Advice Remark Codes (RARCs) and Claim Adjustment Reason Codes (CARCs), effective April 1, 2011. Be sure your billing staff is 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 list is updated 3 times a year – in early March, July, and November, although the Committee meets every month.

Both code lists are posted at http://www.wpc-edi.com/reference/ on the Washington Publishing Company (WPC) website. The lists at the end of this article summarize the latest changes to these lists, as announced in CR7250.

Additional Information

To see the official instruction (CR7250) issued to your Medicare Carrier, RHHI, DME/MAC, FI and/or MAC, refer to http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2131CP.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.

News Flash - Get Your Flu Vaccine - Not the Flu. Don't forget to immunize yourself and your staff. Protect your patients. Protect your family. Protect yourself. While seasonal flu outbreaks can happen as early as October, flu activity usually peaks in January. This year's vaccine will protect against three different flu viruses, including the H1N1 virus that caused so much illness last flu season. The risks for complications, hospitalizations, and deaths from the flu are higher among individuals aged 65 years and older. Medicare pays for the seasonal flu vaccine and its

administration for seniors and others with Medicare with no co-pay or deductible. Health care workers, who may spread the flu to high risk patients, should get vaccinated too. Remember – Influenza vaccine plus its administration are covered Part B benefits. Note that influenza vaccine is NOT a Part D covered drug. For information about Medicare's coverage of the influenza vaccine and its administration, as well as related educational resources for health care staff, please visit http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Flu_Products.pdf and http://www.cms.gov/Medicare/Prevention/Immunizations/index.html on the CMS website.

New Codes - CARC

Code	Current Narrative	Effective Date Per WPC Posting
W2	Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies, use only if no other code is applicable. Note: If adjustment is at the Claim Level, the payer must send, and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send, and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation only.	10/17/2010

Modified Codes - CARC

Code	Modified Narrative	Effective Date Per WPC Posting
191	Not a work related injury/illness and thus not the liability of the workers' compensation carrier. This change effective 7/1/2011: Not a work related injury/illness and thus not the liability of the workers' compensation carrier. Note: If an adjustment is at the Claim Level, the payer must send, and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send, and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).	10/17/10
214	Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment. (Note: To be used for Workers' Compensation only) This change effective 7/1/2011: Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment. Note: If adjustment is at the Claim Level, the payer must send, and the provider should refer to the 835	10/17/2010

Code	Modified Narrative	Effective Date Per WPC Posting
	Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send, and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation only	
218	Based on entitlement to benefits (Note: To be used for Workers' Compensation only) This change effective 7/1/2011: Based on entitlement to benefits. Note: If adjustment is at the Claim Level, the payer must send, and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send, and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation only.	10/17/2010
219	Based on extent of injury (Note: To be used for Workers' Compensation only) This change effective 7/1/2011: Based on extent of injury. Note: If adjustment is at the Claim Level, the payer must send, and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send, and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).	10/17/2010
221	Workers' Compensation claim is under investigation. (Note: To be used for Workers' Compensation only. Claim pending final resolution). This change effective 7/1/2011: Workers' Compensation claim is under investigation. Note: If adjustment is at the Claim Level, the payer must send, and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send, and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).	10/17/2010
W1	Workers Compensation State Fee Schedule Adjustment. This change effective 7/1/2011: Workers' compensation jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send, and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). If adjustment is at the Line Level, the payer must send, and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF).	10/17/2010

Deactivated Codes - CARC

None

New Codes - RARC

Code	Current Narrative	Medicare Initiated
N540	Payment adjusted based on the interrupted stay policy.	Yes
N541	Mismatch between the submitted insurance type code and the information stored in our system.	Yes

Modified Codes - RARC

Code	Modified Narrative	Medicare Initiated
M25	The information furnished does not substantiate the need for this level of 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 level of service, or if you notified the patient in writing in advance that we would not pay for this level of 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 an appeal, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her in excess of any deductible and coinsurance amounts. We will recover the reimbursement from you as an overpayment.	No

Deactivated Codes - RARC

None