CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1475	**Date: March 7, 2008**
	Change Request 5942

SUBJECT: Remittance Advice Remark Code (RARC) and Claim Adjustment Reason Code (CARC) Update

I. SUMMARY OF CHANGES: This Change Request (CR) instructs contractors and Shared System Maintainers to update the Remittance Advice Remark Codes and Claim Adjustment Reason Codes used in paper and electronic Remittance Advice. This also instructs VIPs to update the code database to be used in conjunction with the software - Medicare Remit Easy Print (MREP).

NEW / REVISED MATERIAL
EFFECTIVE DATE: *April 1, 2008
IMPLEMENTATION DATE: April 7, 2008

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-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
N/A	

III. FUNDING:
SECTION A: For Fiscal Intermediaries and 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.

IV. ATTACHMENTS:

Recurring Update Notification

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

Attachment – Recurring Update Notification

Pub. 100-04	Transmittal: 1475	Date: March 7, 2008	Change Request: 5942

SUBJECT: Remittance Advice Remark Code (RARC) and Claim Adjustment Reason Code (CARC) Update

EFFECTIVE DATE: April 1, 2008

IMPLEMENTATION DATE: April 7, 2008

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 Remittance Advice Remark Codes (RARCs) are required in the remittance advice transaction.

X12N 835 Health Care Remittance Advice Remark Codes

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 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 claim payment. CMS as the X12 recognized maintainer of RARCs receives requests from Medicare and non- Medicare payers 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 shall use the modified code even though the modification was not initiated by Medicare. Shared System Maintainers 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. 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 WPC web site because the code list is updated 3 times a year and does not align with the Medicare release schedule. Please note that you shall accept a deactivated reason code used in derivative messages even after the code is deactivated**. Medicare contractors shall not use any deactivated remark code past the deactivation date whether the deactivation is requested by Medicare or any other entity**. **A**

comprehensive list of all deactivated and scheduled to be deactivated RARCs is attached – Attachment 1. The complete list of remark codes is available at:

http://www.wpc-edi.com/codes

The RARC list is updated 3 times a year – in early March, July, and November. By April 1, 2008 contractors shall complete entry of all applicable code text changes and new codes, and the Shared System Maintainers shall implement all code deactivations.

Contractors must use the latest approved and valid codes in the 835, corresponding standard paper remittance advice, and coordination of benefits transactions. CMS has developed a new Web site to help navigate the RARC database more easily. A tool is provided to help search if you are looking for a specific category of code. At this site you can find some other information that is also available from the WPC Web site. The new Web site address is: http://www.cmsremarkcodes.info/

NOTE I: This Web site is not replacing the WPC Web site as the official site where the most current RARC list resides. If there is any discrepancy, always use the list posted at the WPC Web site.

NOTE II: 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 an adjustment. Codes that are "Informational" will have "Alert" in the text to identify them as informational rather than explanatory codes. An example of an informational code:

N369 Alert: Although this claim has been processed, it is deficient according to state legislation/regulation.

The above information is sent per state regulation, but does not explain any 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. A number of remark codes have been identified as "Informational" and have been modified by adding the word "Alert" in front of the text. These codes may be used without any CARC explaining a specific adjustment.

Remittance Advice Remark Code changes

New Codes

Code	Current Narrative	Medicare Initiated
N430	Procedure code is inconsistent with the units billed. Start: 11/5/2007 *Note: (New Code 11/5/07)*	YES
N431	Service is not covered with this procedure. Start: 11/5/2007 *Note: (New Code 11/5/07)*	YES
N432	Adjustment based on a Recovery Audit. Start: 11/5/2007 *Note: (New Code 11/5/07)*	YES

Modified Codes

Code	Current Modified Narrative	Last Modified
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.	11/5/2007
M26	The information furnished does not substantiate the need for this level of service. If you have collected any amount from the patient for this level of service /any amount that exceeds the limiting charge for the less extensive service, the law requires you to refund that amount to the patient within 30 days of receiving this notice. The requirements for refund are in 1824(I) 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. If you have any questions about this notice, please contact this office.	11/5/2007
M75	Multiple automated multichannel tests performed on the same day combined for payment.	11/5/2007
M112	Reimbursement for this item is based on the single payment amount required under the DMEPOS Competitive Bidding Program for the area where the patient resides.	11/5/2007
M113	Our records indicate that this patient began using this item/service prior to the current contract period for the DMEPOS Competitive Bidding Program.	11/5/2007
M114	This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or a Demonstration Project. For more information regarding these projects, contact your local contractor.	11/5/2007

M115	This item is denied when provided to this patient by a non-contract or non-demonstration supplier.	11/5/2007
N70	Consolidated billing and payment applies. .	11/5/2007
N367	**Alert:** The claim information has been forwarded to a Consumer Account Fund processor for review.	11/5/2007
N377	Payment based on a processed replacement claim.	11/5/2007
N385	Notification of admission was not timely according to published plan procedures.	11/5/2007

Deactivated Codes

Code	Current Narrative	Last Modified
MA119	Provider level adjustment for late claim filing applies to this claim. Start: 1/1/1997 | Stop: 5/1/2008 | Last Modified: 11/5/2007 *Note: (Deactivated eff. 5/1/08) Consider using Reason Code B4.*)	Deactivated eff. 5/1/08

X12 N 835 Health Care Claim Adjustment Reason Codes

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 3 times a year around early November, March, and July. To access the list select http://www.wpc-edi.com/codes. Select Claim Adjustment Reason Codes from the pull down menu.

During the last meeting, the committee decided on the following schedule for deactivations and modifications when the change does not become effective when published:

Decision Made	Effective Date
Jan/Feb	October 1
June	January 1

Sep/Oct April 1

The new codes will be effective when published. A modification may also be effective when published if the requester provides justification for an earlier implementation/effective date for the change. The regular code update CR will establish the implementation date for Medicare contractors and the Shared System Maintainers. **Medicare contractors shall not use any deactivated reason code past the deactivation date whether the deactivation is requested by Medicare or any other entity**. **A comprehensive list of all deactivated and scheduled to be deactivated CARCs is attached – Attachment II.**

New Codes:

Code	**Current Narrative**	**Implementation Date**
212	Administrative surcharges are not covered Start: 11/05/2007	11/05/2007

Modified Codes:

(Note: Codes 15-B20 have been modified to remove the words “adjusted” and “denied” without compromising the meaning. This request came from WEDI 835 SWG to make code text more consistent and less confusing.)

Code	**Modified Narrative**	**Implementation Date**
121	Indemnification adjustment - compensation for outstanding member responsibility. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
192	Non standard adjustment code from paper remittance. Note: This code is to be used by providers/payers providing Coordination of Benefits information to another payer in the 837 transaction only. This code is only used when the non-standard code cannot be reasonably mapped to an existing Claims Adjustment Reason Code, specifically Deductible, Coinsurance and Co-payment. Start: 10/31/2005 | Last Modified: 09/30/2007	4/1/2008
206	National Provider Identifier - missing. Start: 07/09/2007 | Last Modified: 09/30/2007	4/1/2008
207	National Provider identifier - Invalid format Start: 07/09/2007 | **Stop: 05/23/2008** | Last Modified: 09/30/2007	4/1/2008 (This code will be deactivated on 5/23/2008)
208	National Provider Identifier - Not matched. Start: 07/09/2007 | Last Modified: 09/30/2007	4/1/2008

15	The authorization number is missing, invalid, or does not apply to the billed services or provider. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
17	Requested information was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
19	This is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
20	This injury/illness is covered by the liability carrier. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
21	This injury/illness is the liability of the no-fault carrier. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
22	This care may be covered by another payer per coordination of benefits. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
23	The impact of prior payer(s) adjudication including payments and/or adjustments. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
24	Charges are covered under a capitation agreement/managed care plan. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
31	Patient cannot be identified as our insured. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
33	Insured has no dependent coverage. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
34	Insured has no coverage for newborns. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
55	Procedure/treatment is deemed experimental/investigational by the payer. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
56	Procedure/treatment has not been deemed `proven to be effective' by the payer. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008

58	Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
61	Penalty for failure to obtain second surgical opinion. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
95	Plan procedures not followed. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
107	The related or qualifying claim/service was not identified on this claim. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
108	Rent/purchase guidelines were not met. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
112	Service not furnished directly to the patient and/or not documented. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
115	Procedure postponed, canceled, or delayed. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
116	The advance indemnification notice signed by the patient did not comply with requirements. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
117	Transportation is only covered to the closest facility that can provide the necessary care. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
118	ESRD network support adjustment. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008

125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
129	Prior processing information appears incorrect. Start: 02/28/1997 | Last Modified: 09/30/2007	4/1/2008
135	Interim bills cannot be processed. Start: 10/31/1998 | Last Modified: 09/30/2007	4/1/2008
136	Failure to follow prior payer's coverage rules. (Use Group Code OA). Start: 10/31/1998 | Last Modified: 09/30/2007	4/1/2008
137	Regulatory Surcharges, Assessments, Allowances or Health Related Taxes. Start: 02/28/1999 | Last Modified: 09/30/2007	4/1/2008
138	Appeal procedures not followed or time limits not met. Start: 06/30/1999 | Last Modified: 09/30/2007	4/1/2008
141	Claim spans eligible and ineligible periods of coverage. Start: 06/30/1999 | Last Modified: 09/30/2007	4/1/2008
142	Monthly Medicaid patient liability amount. Start: 06/30/2000 | Last Modified: 09/30/2007	4/1/2008
146	Diagnosis was invalid for the date(s) of service reported. Start: 06/30/2002 | Last Modified: 09/30/2007	4/1/2008
148	Information from another provider was not provided or was insufficient/incomplete. Start: 06/30/2002 | Last Modified: 09/30/2007	4/1/2008
150	Payer deems the information submitted does not support this level of service. Start: 10/31/2002 | Last Modified: 09/30/2007	4/1/2008
151	Payer deems the information submitted does not support this many services. Start: 10/31/2002 | Last Modified: 09/30/2007	4/1/2008
152	Payer deems the information submitted does not support this length of service. Start: 10/31/2002 | Last Modified: 09/30/2007	4/1/2008

153	Payer deems the information submitted does not support this dosage. Start: 10/31/2002 | Last Modified: 09/30/2007	4/1/2008
154	Payer deems the information submitted does not support this day's supply. Start: 10/31/2002 | Last Modified: 09/30/2007	4/1/2008
155	Patient refused the service/procedure. Start: 06/30/2003 | Last Modified: 09/30/2007	4/1/2008
157	Service/procedure was provided as a result of an act of war. Start: 09/30/2003 | Last Modified: 09/30/2007	4/1/2008
158	Service/procedure was provided outside of the United States. Start: 09/30/2003 | Last Modified: 09/30/2007	4/1/2008
159	Service/procedure was provided as a result of terrorism. Start: 09/30/2003 | Last Modified: 09/30/2007	4/1/2008
160	Injury/illness was the result of an activity that is benefit exclusion. Start: 09/30/2003 | Last Modified: 09/30/2007	4/1/2008
163	Attachment referenced on the claim was not received. Start: 06/30/2004 | Last Modified: 09/30/2007	4/1/2008
164	Attachment referenced on the claim was not received in a timely fashion. Start: 06/30/2004 | Last Modified: 09/30/2007	4/1/2008
165	Referral absent or exceeded. Start: 10/31/2004 | Last Modified: 09/30/2007	4/1/2008
168	Service(s) have been considered under the patient's medical plan. Benefits are not available under this dental plan. Start: 06/30/2005 | Last Modified: 09/30/2007	4/1/2008
169	Alternate benefit has been provided. Start: 06/30/2005 | Last Modified: 09/30/2007	4/1/2008
173	Service was not prescribed by a physician. Start: 06/30/2005 | Last Modified: 09/30/2007	4/1/2008
174	Service was not prescribed prior to delivery. Start: 06/30/2005 | Last Modified: 09/30/2007	4/1/2008

175	Prescription is incomplete. Start: 06/30/2005 | Last Modified: 09/30/2007	4/1/2008
176	Prescription is not current. Start: 06/30/2005 | Last Modified: 09/30/2007	4/1/2008
177	Patient has not met the required eligibility requirements. Start: 06/30/2005 | Last Modified: 09/30/2007	4/1/2008
178	Patient has not met the required spend down requirements. Start: 06/30/2005 | Last Modified: 09/30/2007	4/1/2008
179	Patient has not met the required waiting requirements. Start: 06/30/2005 | Last Modified: 09/30/2007	4/1/2008
180	Patient has not met the required residency requirements. Start: 06/30/2005 | Last Modified: 09/30/2007	4/1/2008
181	Procedure code was invalid on the date of service. Start: 06/30/2005 | Last Modified: 09/30/2007	4/1/2008
182	Procedure modifier was invalid on the date of service. Start: 06/30/2005 | Last Modified: 09/30/2007	4/1/2008
186	Level of care change adjustment. Start: 06/30/2005 | Last Modified: 09/30/2007	4/1/2008
191	Not a work related injury/illness and thus not the liability of the workers' compensation carrier. Start: 10/31/2005 | Last Modified: 09/30/2007	4/1/2008
194	Anesthesia performed by the operating physician, the assistant surgeon or the attending physician. Start: 02/28/2006 | Last Modified: 09/30/2007	4/1/2008
195	Refund issued to an erroneous priority payer for this claim/service. Start: 02/28/2006 | Last Modified: 09/30/2007	4/1/2008
197	Precertification/authorization/notification absent. Start: 10/31/2006 | Last Modified: 09/30/2007	4/1/2008
198	Precertification/authorization exceeded. Start: 10/31/2006 | Last Modified: 09/30/2007	4/1/2008
202	Precertification/authorization exceeded. Start: 10/31/2006 | Last Modified: 09/30/2007	4/1/2008

203	Discontinued or reduced service. Start: 02/28/2007 | Last Modified: 09/30/2007	4/1/2008
A8	Ungroupable DRG. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
B5	Coverage/program guidelines were not met or were exceeded. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
B8	Alternative services were available, and should have been utilized. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
B9	Patient is enrolled in a Hospice. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
B14	Only one visit or consultation per physician per day is covered. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
B16	`New Patient' qualifications were not met. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
B18	This procedure code and modifier were invalid on the date of service. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
B20	Procedure/service was partially or fully furnished by another provider. Start: 01/01/1995 | Last Modified: 09/30/2007	4/1/2008
B23	Procedure billed is not authorized per your Clinical Laboratory Improvement Amendment (CLIA) proficiency test. Start: 01/01/1995 | Last Modified: 09/30/2007	

Deactivated Codes:

Code	Current Narrative	Implementation Date

25	Payment denied. Your Stop loss deductible has not been met. Start: 01/01/1995 | Stop: 04/01/2008	4/1/2008
126	Deductible -- Major Medical Start: 02/28/1997 | Stop: 04/01/2008 | Last Modified: 09/30/2007 Notes: Use Group Code PR and code 1.	4/1/2008
127	Coinsurance -- Major Medical Start: 02/28/1997 | Stop: 04/01/2008 | Last Modified: 09/30/2007 Notes: Use Group Code PR and code 2.	4/1/2008
145	Premium payment withholding Start: 06/30/2002 | Stop: 04/01/2008 | Last Modified: 09/30/2007 Notes: Use Group Code CO and code 45.	4/1/2008
A4	Medicare Claim PPS Capital Day Outlier Amount. Start: 01/01/1995 | Stop: 04/01/2008 | Last Modified: 09/30/2007	4/1/2008

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 on a regular basis. Medicare contractors must report only currently valid codes in both the remittance advice and COB Claim transaction. Shared System Maintainers and contractors must 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.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

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	
5942.1	A/B MACs, carriers, DME MACs, FIs, and RHHIs	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	
	shall update remark codes that have been modified and apply to Medicare by April1, 2008.										
5942.2	A/B MACs, carriers, DME MACs, FIs, and RHHIs shall update remark codes to include new codes that apply to Medicare by April 1, 2008.	X	X	X	X	X					
5942.3	Shared System Maintainers shall make necessary programming changes so that no deactivated code is reported in the remittance advice or the COB claim by April 1, 2008. NOTE: Comprehensive lists of deactivated CARCs and RARCs are attached –Attachments I and II						X	X	X		
5942.4	Shared System Maintainers shall make necessary programming changes by April 1, 2008, so that deactivated codes are allowed in derivative messages even after the deactivation effective date.						X	X	X		
5942.5	VMS shall update the Medicare Remit Easy Print software to include the most current CARC and RARC lists available from the following Web site: http://www.wpc-edi.com/codes (Note: This update will be provided in a separate file starting in April, 2008.)								X		
5942.6	A/B MACs, carriers, and DME MACs shall notify the users that the code update file must be downloaded to be used in conjunction with the current software. (Note: The software will be updated if there is any enhancement to be implemented. If there is no enhancement needed, the code update file will be used with the existing software).	X	X		X						

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	
5942.7	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	X	X					

IV. SUPPORTING INFORMATION

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

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

V. CONTACTS

Pre-Implementation Contact(s): Sumita Sen, 410-786-5755, sumita.sen@cms.hhs.gov

Post-Implementation Contact(s): Sumita Sen, 410-786-5755, sumita.sen@cms.hhs.gov

VI. FUNDING

A. ***For Fiscal Intermediaries, Carriers and Regional Home Health Intermediaries (RHHI), use the following statement*****:**
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

B. ***For Medicare Administrative Contractors (MAC), use the following statement*****:**
The Medicare Administrative Contractor (MAC) is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as changes to the MAC Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts specified 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.

Attachment I – Comprehensive List of Deactivated Remittance Advice Remark Codes
Attachment II – Comprehensive List of Deactivated Claim Adjustment Reason Codes

Comprehensive List of Deactivated Remittance Advice Remark Codes
(As of 11/5/2007)

ATTACHMENT - I				
RARC #	**TEXT**	**DEACTIV. DATE**	**REPLACEMENT CODE, IF AVAILBLE**	**Comment**
M33	Missing/incomplete/invalid UPIN for the ordering/referring/performing provider.	**8/1/2004**	M68	
M34	Claim lacks the CLIA certification number.	**8/1/2004**	MA120	
M35	Missing/incomplete/invalid pre-operative photos or visual field results.	**2/5/2005**	N178	
M43	Payment for this service previously issued to you or another provider by another carrier/intermediary.	**1/31/2004**	CARC 23	
M48	Payment for services furnished to hospital inpatients (other than professional services of physicians) can only be made to the hospital. You must request payment from the hospital rather than the patient for this service.	**1/31/2004**	M97	
M57	Missing/incomplete/invalid provider identifier.	**6/2/2005**		No one replacement code because this code has been broken down to different types of providers
M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.	**2/5/2005**		This generic code was deactivated and new codes were created with more specificity. Use specific code for a specific situation.
M63	We do not pay for more than one of these on the same day.	**1/31/2004**	M86	
M68	Missing/incomplete/invalid attending, ordering, rendering, supervising or referring physician identification.	**6/2/2005**		No one replacement code because this code has been broken down to different types of providers
M72	Did not enter full 8-digit date (MM/DD/CCYY).	**10/16/2003**	MA52	
M78	Missing/incomplete/invalid HCPCS modifier.	**5/18/2006**	CARC 4	
M88	We cannot pay for laboratory tests unless billed by the laboratory that did the work.	**8/1/2004**	CARC B20	
M92	Services subjected to review under the Home Health Medical Review Initiative.	**8/1/2004**		
M98	Begin to report the Universal Product Number on claims for items of this type. We will soon begin to deny payment for items of this type if billed without the correct UPN.	**1/31/2004**	M99	
M101	Begin to report a G1-G5 modifier with this HCPCS. We will soon begin to deny payment for this service if billed without a G1-G5 modifier.	**1/31/2004**	M78	
M106	Information supplied does not support a break in therapy. A new capped rental period will not begin. This is the maximum approved under the fee schedule for this item or service.	**1/31/2004**	MA31	
M108	Missing/incomplete/invalid provider identifier for the provider who interpreted the diagnostic test.	**6/2/2005**		New code has been created for every type of provider mentioned in the 837 IGs

Comprehensive List of Deactivated Remittance Advice Remark Codes
(As of 11/5/2007)

ATTACHMENT - I

RARC #	TEXT	DEACTIV. DATE	REPLACEMENT CODE, IF AVAILBLE	Comment
M110	Missing/incomplete/invalid provider identifier for the provider from whom you purchased interpretation services.	6/2/2005		New code has been created for every type of provider mentioned in the 837 IGs
M120	Missing/incomplete/invalid provider identifier for the substituting physician who furnished the service(s) under a reciprocal billing or locum tenens arrangement.	6/2/2005		New code has been created for every type of provider mentioned in the 837 IGs
M128	Missing/incomplete/invalid date of the patient's last physician visit.	6/2/2005		New code has been created for every type of provider mentioned in the 837 IGs
M140	Service not covered until after the patient's 50th birthday, i.e., no coverage prior to the day after the 50th birthday	1/30/2004	M82	
MA03	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 within six months of the date of this notice. To meet the $100, you may combine amounts on other claims that have been denied, including reopened appeals if you received a revised decision. You must appeal each claim on time.	11/18/2005	MA02	
MA05	Incorrect admission date patient status or type of bill entry on claim.	10/16/2003	MA30/ MA40/ MA43	
MA06	Missing/incomplete/invalid beginning and/or ending date(s).	8/1/2004	MA31	
MA11	Payment is being issued on a conditional basis. If no-fault insurance, liability insurance, Workers' Compensation, Department of Veterans Affairs, or a group health plan for employees and dependents also covers this claim, a refund may be due us. Please contact us if the patient is covered by any of these sources.	1/31/2004	M32	
MA29	Missing/incomplete/invalid provider name, city, state, or zip code.	6/2/2005		No one replacement because this code has been broken down to different types of prviders
MA38	Missing/incomplete/invalid birth date.	6/2/2005		No one replacement code because this code has been broken down to different types of providers
MA49	Missing/incomplete/invalid six-digit provider identifier for home health agency or hospice for physician(s) performing care plan oversight services.	8/1/2004	MA76	
MA51	Missing/incomplete/invalid CLIA certification number for laboratory services billed by physician office laboratory.	2/5/2005	MA120	
MA52	Missing/incomplete/invalid date.	6/2/2005		
MA78	The patient overpaid you. You must issue the patient a refund within 30 days for the difference between our allowed amount total and the amount paid by the patient.	1/31/2004	MA59	
MA82	Missing/incomplete/invalid provider/supplier billing number/identifier or billing name, address, city, state, zip code, or phone number.	6/2/2005		No one replacement because this code has been broken down to more specific codes

Comprehensive List of Deactivated Remittance Advice Remark Codes
(As of 11/5/2007)

ATTACHMENT - I

RARC #	TEXT	DEACTIV. DATE	REPLACEMENT CODE, IF AVAILBLE	Comment
MA85	Our records indicate that a primary payer exists (other than ourselves); however, you did not complete or enter accurately the insurance plan/group/program name or identification number. Enter the PlanID when effective.	**8/1/2004**	MA92	
MA86	Missing/incomplete/invalid group or policy number of the insured for the primary coverage.	**8/1/2004**	MA92	
MA87	Missing/incomplete/invalid insured's name for the primary payer.	**8/1/2004**	MA92	
MA98	Claim Rejected. Does not contain the correct Medicare Managed Care Demonstration contract number for this beneficiary.	**10/16/2003**	MA97	
MA102	Missing/incomplete/invalid name or provider identifier for the rendering/referring/ ordering/ supervising provider.	**8/1/2004**	M68	
MA104	Missing/incomplete/invalid date the patient was last seen or the provider identifier of the attending physician.	**1/31/2004**	M128/M57	
MA105	Missing/incomplete/invalid provider number for this place of service.	**6/2/2005**		No one replacement code because this code has been broken down to different types of providers
MA124	Processed for IME only.	**1/31/2004**	CARC 74	
MA127	Reserved for future use.	**6/2/2005**		No need to have a replacement code
MA129	This provider was not certified for this procedure on this date of service.	**1/31/2004**	MA120/CARC B7	
N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.	**10/1/2007**	CARC 45	
N17	Per admission deductible.	**8/1/2004**	CARC 1	
N18	Payment based on the Medicare allowed amount.	**1/31/2004**	N14	
N38	Missing/incomplete/invalid place of service.	**2/5/2005**	M77	
N41	Authorization request denied.	**10/16/2003**	CARC 39	
N44	Payer's share of regulatory surcharges, assessments, allowances or health care-related taxes paid directly to the regulatory authority.	**10/16/2003**	CARC 137	
N60	A valid NDC is required for payment of drug claims effective October 02.	**1/31/2004**	M119	
N66	Missing/incomplete/invalid documentation.	**2/5/2005**	N29/N225	
N73	A Skilled Nursing Facility is responsible for payment of outside providers who furnish these services/supplies under arrangement to its residents.	**1/31/2004**	MA101/N200	
N101	Additional information is needed in order to process this claim. Please resubmit the claim with the identification number of the provider where this service took place. The Medicare number of the site of service provider should be preceded with the letters "HSP" and entered into item #32 on the claim form. You may bill only one site of service provider number per claim.	**1/31/2004**	MA105	

Comprehensive List of Deactivated Remittance Advice Remark Codes
(As of 11/5/2007)

ATTACHMENT - I

RARC #	TEXT	DEACTIV. DATE	REPLACEMENT CODE, IF AVAILBLE	Comment
N145	Missing/incomplete/invalid provider identifier for this place of service.	**6/2/2005**		No one replacement code because this code has been broken down to different types of providers
N164	Transportation to/from this destination is not covered.	**1/31/2004**	N157	
N165	Transportation in a vehicle other than an ambulance is not covered.	**1/31/2004**	N158	
N166	Payment denied/reduced because mileage is not covered when the patient is not in the ambulance.	**1/31/2004**	N159	
N168	The patient must choose an option before a payment can be made for this procedure/ equipment/ supply/ service.	**1/31/2004**	N160	
N169	This drug/service/supply is covered only when the associated service is covered.	**1/31/2004**	N161	
N361	Payment adjusted based on multiple diagnostic imaging procedure rules	**10/1/2007**	CARC 59	
MA119	Provider level adjustment for late claim filing applies to this claim.	**5/1/2008**	CARC B4	
N411	This service is allowed one time in a 6-month period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.)	**2/1/2009**		Temporary code created for the Dental Industry
N412	This service is allowed 2 times in a 12-month period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.)	**2/1/2009**		Temporary code created for the Dental Industry
N413	This service is allowed 2 times in a benefit year. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.)	**2/1/2009**		Temporary code created for the Dental Industry
N414	This service is allowed 4 times in a 12-month period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.)	**2/1/2009**		Temporary code created for the Dental Industry
N415	This service is allowed 1 time in an 18-month period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.)	**2/1/2009**		Temporary code created for the Dental Industry
N416	This service is allowed 1 time in a 3-year period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.)	**2/1/2009**		Temporary code created for the Dental Industry
N417	This service is allowed 1 time in a 5-year period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.)	**2/1/2009**		Temporary code created for the Dental Industry
NOTE:	For M57, M68, M108, M 110, M120, and MA29 See N247-N298			

Comprehensive List of Deactivated Claim Adjustment Reason Codes
(As of 11/5/2007)

Attachment-II

CARC #	TEXT	DEACTIV. DATE	REPLACEMENT CODE, IF AVAILBLE	Comment
28	Coverage not in effect at the time the service was provided.	**10/16/2003**		*Notes: Redundant to codes 26&27.*
30	Payment adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.	**2/1/2006**		
36	Balance does not exceed co-payment amount.	**10/16/2003**		Not needed
37	Balance does not exceed deductible.	**10/16/2003**		Not needed
41	Discount agreed to in Preferred Provider contract.	**10/16/2003**		Contractual Agreement
42	Charges exceed our fee schedule or maximum allowable amount. (Use CARC 45)	**6/1/2007**	45	
43	Gramm-Rudman reduction.	**7/1/2006**		Not needed
46	This (these) service(s) is (are) not covered.	**10/16/2003**	96	
47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.	**2/1/2006**		
48	This (these) procedure(s) is (are) not covered.	**10/16/2003**	96	
52	The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.	**2/1/2006**		
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.	**6/30/2007**		Split into 150, 151, 152, 153 and 154. Use the most relevant code instead of generic 57
62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.	**4/1/2007**		
63	Correction to a prior claim.	**10/16/2003**		
64	Denial reversed per Medical Review.	**10/16/2003**		
65	Procedure code was incorrect. This payment reflects the correct code.	**10/16/2003**		No need for a code. Covered within the 835
67	Lifetime reserve days. (Handled in QTY, QTY01=LA)	**10/16/2003**		No need for a code. Covered within the 835
68	DRG weight. (Handled in CLP12)	**10/16/2003**		No need for a code. Covered within the 835
71	Primary Payer amount.	**6/30/2000**	23	No need for a code. Covered within the 835
72	Coinsurance day. (Handled in QTY, QTY01=CD)	**10/16/2003**		No need for a code. Covered within the 835
73	Administrative days.	**10/16/2003**		No need for a code. Covered within the 835
77	Covered days. (Handled in QTY, QTY01=CA)	**10/16/2003**		No need for a code. Covered within the 835
79	Cost Report days. (Handled in MIA15)	**10/16/2003**		No need for a code. Covered within the 835
80	Outlier days. (Handled in QTY, QTY01=OU)	**10/16/2003**		No need for a code. Covered within the 835
81	Discharges.	**10/16/2003**		No need for a code. Covered within the 835
83	Total visits.	**10/16/2003**		No need for a code. Covered within the 835
84	Capital Adjustment. (Handled in MIA)	**10/16/2003**		No need for a code. Covered within the 835
86	Statutory Adjustment.	**10/16/2003**	45	
88	Adjustment amount represents collection against receivable created in prior overpayment.	**6/30/2007**		No need for a code. Covered within the 835
92	Claim Paid in full.	**10/16/2003**		Not needed.
93	No Claim level Adjustments.	**10/16/2003**		Not needed
98	The hospital must file the Medicare claim for this inpatient non-physician service.	**10/16/2003**		
99	Medicare Secondary Payer Adjustment Amount.	**10/16/2003**		
113	Payment denied because service/procedure was provided outside the United States or as a result of war.	**6/30/2007**	157, 158, 159	
120	Patient is covered by a managed care plan.	**6/30/2007**	24	
123	Payer refund due to overpayment.	**6/30/2007**		*Notes: Refer to implementation guide for proper handling of reversals.*
124	Payer refund amount - not our patient.	**6/30/2007**		*Notes: Refer to implementation guide for proper handling of reversals.*
196	Claim/service denied based on prior payer's coverage determination.	**2/1/2007**	136	
A3	Medicare Secondary Payer liability met.	**10/16/2003**		

Comprehensive List of Deactivated Claim Adjustment Reason Codes
(As of 11/5/2007)

Attachment-II

CARC #	TEXT	DEACTIV. DATE	REPLACEMENT CODE, IF AVAILBLE	Comment
B2	Covered visits.	**10/16/2003**		No need for a code. Covered within the 835
B3	Covered charges.	**10/16/2003**		No need for a code. Covered within the 835
B6	This payment is adjusted when performed/billed by this type of provider, by this type of provider in this type of facility, or by a provider of this specialty.	**2/1/2006**		
B17	Payment adjusted because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current.	**2/1/2006**		
B19	Claim/service adjusted because of the finding of a Review Organization.	**10/16/2003**		
B21	The charges were reduced because the service/care was partially furnished by another physician.	**10/16/2003**		
D1	Claim/service denied. Level of subluxation is missing or inadequate.	**10/16/2003**	16+relevant RARC	
D2	Claim lacks the name, strength, or dosage of the drug furnished.	**10/16/2003**	16+relevant RARC	
D3	Claim/service denied because information to indicate if the patient owns the equipment that requires the part or supply was missing.	**10/16/2003**	16+relevant RARC	
D4	Claim/service does not indicate the period of time for which this will be needed.	**10/16/2003**	16+relevant RARC	
D5	Claim/service denied. Claim lacks individual lab codes included in the test.	**10/16/2003**	16+relevant RARC	
D6	Claim/service denied. Claim did not include patient's medical record for the service.	**10/16/2003**	16+relevant RARC	
D7	Claim/service denied. Claim lacks date of patient's most recent physician visit.	**10/16/2003**	16+relevant RARC	
D8	Claim/service denied. Claim lacks indicator that `x-ray is available for review.'	**10/16/2003**	16+relevant RARC	
D9	Claim/service denied. Claim lacks invoice or statement certifying the actual cost of the lens, less discounts or the type of intraocular lens used.	**10/16/2003**	16+relevant RARC	
D10	Claim/service denied. Completed physician financial relationship form not on file.	**10/16/2003**	17+relevant RARC	
D11	Claim lacks completed pacemaker registration form.	**10/16/2003**	17+relevant RARC	
D12	Claim/service denied. Claim does not identify who performed the purchased diagnostic test or the amount you were charged for the test.	**10/16/2003**	17+relevant RARC	
D13	Claim/service denied. Performed by a facility/supplier in which the ordering/referring physician has a financial interest.	**10/16/2003**	17+relevant RARC	
D14	Claim lacks indication that plan of treatment is on file.	**10/16/2003**	17+relevant RARC	
D15	Claim lacks indication that service was supervised or evaluated by a physician.	**10/16/2003**	17+relevant RARC	
D16	Claim lacks prior payer payment information.	**6/30/2007**	16+N4	
D17	Claim/Service has invalid non-covered days.	**6/30/2007**	16+relevant RARC	
D18	Claim/Service has missing diagnosis information.	**6/30/2007**	16+relevant RARC	
D19	Claim/Service lacks Physician/Operative or other supporting documentation	**6/30/2007**	16+relevant RARC	
D20	Claim/Service missing service/product information.	**6/30/2007**	16+relevant RARC	
D21	This (these) diagnosis(es) is (are) missing or are invalid	**6/30/2007**		
25	Payment denied. Your Stop loss deductible has not been met.	**4/1/2008**	Group Code PR and 1	
126	Deductible -- Major Medical	**4/1/2008**	Group Code PR and 1	
127	Coinsurance -- Major Medical	**4/1/2008**	Group Code PR and 2	
145	Premium payment withholding	**4/1/2008**	Group Code CO and 45	
207	NPI denial - Invalid format. This change effective 4/1/2008: National Provider identifier - Invalid format	**5/23/2008**		

Comprehensive List of Deactivated Claim Adjustment Reason Codes
(As of 11/5/2007)

Attachment-II

CARC #	TEXT	DEACTIV. DATE	REPLACEMENT CODE, IF AVAILBLE	Comment
A2	Contractual adjustment.	**1/1/2008**	Group Code CO and 45 or another specific CARC	
A4	Medicare Claim PPS Capital Day Outlier Amount.	**4/1/2008**		No replacement code as Medicare does not use it.