| CMS Manual System | **Department of Health & Human Services (DHHS)** |
|---|---|
| Pub 100-04 Medicare Claims Processing | **Centers for Medicare & Medicaid Services (CMS)** |
| **Transmittal 3288** | **Date: July 2, 2015** |
| | **Change Request 9199** |

**SUBJECT: Medicare Internet Only Manual Publication 100-04 Chapter 22 Remittance Advice**

**I. SUMMARY OF CHANGES:** The purpose of this Change Request (CR) is to modify the current version of Pub. 100-04, chapter 22 - Remittance Advice to remove outdated information. Additional clarification of instruction has been added to this chapter.

**EFFECTIVE DATE: August 3, 2015**
**Unless otherwise specified, the effective date is the date of service.*
**IMPLEMENTATION DATE: August 3, 2015**

***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 |
|---|---|
| R | 22/Table of Contents |
| R | 22/10/Background |
| R | 22/30/Remittance Balancing |
| R | 22/40 Electronic Remittance Advice - ERA or ASC X12 835 |
| R | 22/40.1/ASC X12 835 |
| R | 22/40.4/Medicare Standard Electronic PC-Print Software for Institutional Providers |
| R | 22/40.5/Medicare Remit Easy Print Software for Professional Providers and Suppliers |
| R | 22/50/Standard Paper Remittance Advice |
| D | 22/50.2/SPR Formats |
| D | 22/50.2.1/Part A (A/B MACs/FIs/RHHIs) SPR Format |
| D | 22/50.2.2/Part B (A/B MACs/Carrier/DMERC/DME MAC) SPR Format |
| D | 22/50.3/Part A(A/B MAC/FI/RHHI) SPR Crosswalk to the 835 |
| D | 22/50.4/Part B (A/B MAC/Carrier/DMERC/DME MAC)SPR Crosswalk to the 835 |
| R | 22/60.2/Claim Adjustment Reason Codes |

| R/N/D | CHAPTER / SECTION / SUBSECTION / TITLE |
|---|---|
| R | 22/60.3/Remittance Advice Remark Codes |
| R | 22/60.4/Requests for Additional Codes |
| D | 22/70.1/Scope of Remittance Changes for HH PPS |
| D | 22/70.2/Payment Methodology of the HH PPS Remittance: HIPPS Codes |
| D | 22/70.3/Items Not Included in HH PPS Episode Payment |
| D | 22/70.4/835 Version 004010A1 Line Level Reporting Requirements for the Request for Anticipated Payment (RAP) Payment for an Episode |
| D | 22/70.5/835 Version 004010A1 Line Level Reporting Requirements for the Claim Payment in an Episode (More Than Four Visits) |
| D | 22/70.6/835 Version 004010A1 Line Level Reporting Requirements for the Claim Payment in an Episode (Four or Fewer Visits) |
| D | 22/70.7/HH PPS Partial Episode Payment (PEP) Adjustment |
| R | 22/80/The Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) Mandated Operating Rules |
| R | 22/80.1/Health Care Claim Payment/Advice (835) Infrastructure Rule |
| R | 22/80.2/Uniform Use of CARCs and RARCs Rule |
| R | 22/80.3/EFT Enrollment Data Rule |
| R | 22/80.4/ERA Enrollment Form |
| D | 22/90/General Remittance Completion Requirements |
| D | 22/100/Remittance Balancing |
| D | 22/110/Electronic Remittance Advice – ERA or 835 |
| D | 22/110.1/ANSI ASC X12N 835 |
| D | 22/110.2/Generating an ERA if Required Data is Missing or Invalid |
| D | 22/110.3/Electronic Remittance Advice Data Sent to Banks |
| D | 22/110.4/Medicare Standard Electronic PC-Print Software for Institutional Providers |
| D | 22/110.5/Medicare Remit Easy Print Software for Professional Providers and Suppliers |
| D | 22/110.6/835 Implementation Guide (IG) or Technical Report 3(TR3) |
| D | 22/120/Standard Paper Remittance Advice |
| D | 22/120.1/The Do Not Forward (DNF) Initiative |
| D | 22/120.2/SPR Formats |
| D | 22/120.2.1/Part A (A/B MACs/FIs/RHHIs) SPR Format |
| D | 22/120.2.2/Part B (A/B MACs/Carriers/ /DME MACs) SPR Format |
| D | 22/130/Remittance Advice Codes |
| D | 22/130.1/Group Codes |

| R/N/D | CHAPTER / SECTION / SUBSECTION / TITLE |
|---|---|
| D | 22/130.2/Claim Adjustment Reason Codes |
| D | 22/130.3/Remittance Advice Remark Codes |
| D | 22/130.4/Requests for Additional Codes |

**III. FUNDING:**

**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:**

**Business Requirements**
**Manual Instruction**

# Attachment - Business Requirements

| Pub. 100-04 | Transmittal: 3288 | Date: July 2, 2015 | Change Request: 9199 |
|---|---|---|---|

**SUBJECT: Medicare Internet Only Manual Publication 100-04 Chapter 22 Remittance Advice**

**EFFECTIVE DATE: August 3, 2015**
*Unless otherwise specified, the effective date is the date of service.*
**IMPLEMENTATION DATE: August 3, 2015**

## I. GENERAL INFORMATION

**A. Background:** Pub. 100-04, chapter 22 - Remittance Advice contained duplicate and outdated information. Revisions of this chapter were made to ensure that information contained within contained relevant and applicable instruction. Duplicative information has been removed.

**B. Policy:** No new policy.

## II. BUSINESS REQUIREMENTS TABLE

*"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.*

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| 9199.1 | Contractors shall follow instruction outlined in attached Pub.100-04, chapter 22 updates. | X | X | X | X | | | | | CEDI |

## III. PROVIDER EDUCATION TABLE

| Number | Requirement | Responsibility | | | | |
|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | CEDI |
| | | A | B | HHH | | |
| | None | | | | | |

## IV. SUPPORTING INFORMATION

**Section A: Recommendations and supporting information associated with listed requirements:** N/A

*"Should" denotes a recommendation.*

| X-Ref Requirement Number | Recommendations or other supporting information: |
|---|---|

**Section B: All other recommendations and supporting information:** N/A

## V. CONTACTS

**Pre-Implementation Contact(s):** Lauren Vandegrift, 410-786-4882 or lauren.vandegrift@cms.hhs.gov , Sheena Pierce, 410-786-3449 or sheena.pierce@cms.hhs.gov

**Post-Implementation Contact(s):** Contact your Contracting Officer's Representative (COR).

## VI. FUNDING

**Section A: 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.

**ATTACHMENTS: 0**

# Medicare Claims Processing Manual
## Chapter 22 - Remittance Advice

**Table of Contents**
***(Rev.3288, Issued: 07-02-15)***

## 10 - Background

***(Rev.3288, Issued: 07-02-15, Effective: 08-03-15, Implementation: 08-03-15)***

*The* A/B Medicare Administrative Contractors (A/B MACs) and Durable Medical Equipment Medicare Administrative Contractors (DME MACs) send providers, physicians, and suppliers, as a companion to claim payments, a notice of payment, referred to as the Remittance Advice (RA). RAs explain the payment and any adjustment(s) made during claim adjudication. For each claim or line item payment, and/or adjustment, there is an associated remittance advice item. Adjustment is defined as:

- denied
- zero payment
- partial payment
- reduced payment
- penalty applied
- additional payment
- supplemental payment

Payments and/or adjustments for multiple claims can be reported on one transmission of the remittance advice. RA notices can be produced and transferred in either paper or electronic format.

*The* A/B MACs and DME MACs also send informational RAs to nonparticipating physicians, suppliers, and non-physician practitioners billing non-assigned claims (billing and receiving payments from beneficiaries instead of accepting direct Medicare payments), unless the beneficiary or the provider requests that the remittance advice be suppressed. An informational RA is identical to other RAs, but must carry a standard message to notify providers that they do not have appeal rights beyond those afforded when limitation on liability (rules regulating the amount of liability that an entity can accrue because of medical services which are not covered by Medicare (see *Pub.* 100-04, *chapter* 30) applies.

*The* MACs are allowed to charge up to a maximum of $25 for generating and mailing, if applicable, duplicate remittance advice (both electronic and paper) to recoup *costs* when generated at the request of a provider or any entity working on behalf of the provider. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) administrative provisions, the Secretary of Health and Human Services has adopted ASC X12 Health Care Claim Payment/Advice (835) version 5010A1 to be the standard effective from January 1, 2012.

*The* CMS has implemented the new HIPAA standard following the ASC X12 Technical Report 3 (TR3) for transaction 835 version 5010A1 and requires the use of this format exclusively for Electronic Remittance Advices (ERAs) on or after full implementation. CMS has also established a policy that the paper formats shall mirror the ERAs as much as possible, and all MACs shall use the paper formats – Standard Paper Remit or SPR - established by CMS.

Provider Identification:

Medicare requires claims to contain National Provider Identifiers (NPIs) to be accepted for adjudication. NPIs received on the claims are cross walked to Medicare assigned legacy numbers for adjudication. Adjudication is based on each unique combination of NPI/legacy number if there is no one-to-one relationship between the two. Any ERA or SPR sent after version 5010A1 has been implemented will have one of the *three* provider identifications: (1) Federal Taxpayer's Identification Number; (2) Centers for Medicare *&* Medicaid Services PlanID; *or* (3) Centers for Medicare *&* Medicaid Services National Provider Identifier (NPI) as the provider ID instead of any Medicare assigned provider number at the provider level. *NPIs* will be sent as the provider identification at the claim level. As the Rendering Provider Identifier at the service line level, any one of the following identifiers: (1) Centers for Medicare *&* Medicaid Services National Provider Identifier; (2) Social Security Number; (3) Federal Tax Payer's Identification Number; *or* (4) Medicare Provider Number – will be sent.

## 30 - Remittance Balancing

***(Rev.3288, Issued: 07-02-15, Effective: 08-03-15, Implementation: 08-03-15)***

For Medicare the principles of remittance balancing are the same for both paper and electronic remittance formats. Balancing requires that the total paid amount is equal to the total submitted charges plus or minus payment adjustments for a single ASC X12 835 remittance in accordance with the rules of the standard ASC X12 835 format. Refer to Front Matter Section 1.10.2.1 for Balancing in the ASC X12 835 version 5010 TR3. Every HIPAA compliant ASC X12 835 transaction issued by a MAC must comply with the ASC X12 835 version 5010 TR3 requirements*;* i.e., these remittances must balance at the service, claim*,* and provider levels. The flat files generated by the shared systems must be balanced at the line, claim, and provider level. As a failsafe measure claim adjustment reason code 121 and PLB reason code 90 may be used at the line, claim*,* and provider level respectively to make sure that the ASC X12 835 is balanced. Shared System generated reports must track the usage of these codes, and A/B MACs and DME MACs must work closely with the shared system maintainers and CMS to resolve the issues resulting in out of balance situations.

## 40 - Electronic Remittance Advice - ERA or ASC X12 835

***(Rev.3288, Issued: 07-02-15, Effective: 08-03-15, Implementation: 08-03-15)***

Electronic Remittance Advice (ERA) transactions must be produced in the current HIPAA compliant ASC X12 835 version /5010. Directions for version updates are posted when necessary in Change Request (CR) instructions issued by CMS. Refer to http://www.wpc-edi.com/reference for implementation guides, record formats, and data dictionaries for the ASC X12 835.

Shared systems maintainers must provide appropriate provider file structures and switching mechanisms so that MACs can select and generate the ASC X12 835 and/or the automated clearinghouse (ACH) format when electronic funds transfer (EFT) applies. See the implementation guides for further information on the abbreviated ASC X12 835 and use of the ASC X12 835 for EFT.

Changes to content and format of ERAs may not be made by individual MACs. Changes will be made only by shared system maintainers, and then, only as directed by CMS.

## 40.1 - ASC X12 835

***(Rev.3288, Issued: 07-02-15, Effective: 08-03-15, Implementation: 08-03-15)***

The ASC X12 835 is a variable-length record designed for wire transmission and is not suitable for use in application programs. Therefore, shared systems generate a flat file version of the ASC X12 835. MACs must translate that flat file into the variable length ASC X12 835 record for transmission to providers or their billing services or clearinghouse. See chapter 24 for technical information about transmission of the ASC X12 835. The updated flat files are posted at:

http://www.cms.hhs.gov/ElectronicBillingEDITrans/11_Remittance.asp#TopOfPage

Go to "Downloads", and click on the file you want.

*The* MAC requirements are:

- Send the remittance data directly to providers or their designated billing services or clearinghouses;

- Provide sufficient security to protect beneficiaries' privacy. The MAC does not allow any party to view beneficiary information, unless authorized by specific instructions from CMS;

- Issue the remittance advice specifications and technical interface specifications to all requesting providers within *3* weeks of their request. Interface specifications must contain sufficient detail to enable a reasonably knowledgeable provider to interpret the RA, without the need to pay the MAC or an associated business under the same corporate umbrella for supplemental services or software;

- A/B MACs (A) allow Part A providers to receive a Standard Paper Remittance Advice (SPR) in addition to the ASC X12 835 during the first 31 days of receiving ERAs and during other testing. After that time, A/B MACs (A) do not send a hard copy version of the ASC X12 835, in addition to the electronic transmission, in production mode. They should contact CMS if this requirement causes undue hardship for a particular provider, and a waiver is needed;

- A/B MACs and DME MACs must suppress the distribution of SPRs to Part B providers/suppliers (or a billing agent, clearinghouse, or other entity receiving ERAs on behalf of those providers/suppliers) *after* 45 days of receiving both SPR and ERA formats. In rare situations (e.g., natural or man-made disasters) exceptions to this policy may be allowed at the discretion of CMS. A/B MACs and DME MACs should contact CMS if a waiver is needed;

- MACs may release an ERA prior to the payment date, but never later than the payment date;

- Ensure that their provider file accommodates the data necessary to affect EFT, either through use of the ACH or the ASC X12 835 format;

- Pay the costs of transmitting EFT through their bank to the ACH. Payees are responsible for the telecommunications costs of EFT from the ACH to their bank, as well as the costs of receiving ASC X12 835 data once in production mode; and

- Provide for sufficient back-up to allow for retransmission of garbled or misdirected transmissions.

Every ASC X12 835 transaction issued by A/B MACs and DME MACs must comply with the implementation guide (IG) requirements; i.e., each required segment, and each situational segment when the situation applies, must be reported. Required or applicable situational data element in a required or situational segment must be reported, and the data in a data element must meet the minimum length and data attribute (AN, ID, R, etc.) specifications in the implementation guide.

Back end validation must be performed to ensure that these conditions are met. A/B MACs and DME MACs are not required to validate codes maintained by their shared systems, such as Healthcare Common Procedure Coding System (HCPCS), that are issued in their shared system's flat file for use in the body of an ASC X12 835, but they are required to validate data in the ASC X12 835 envelope as well as the codes that they maintain, such as claim adjustment reason codes and remittance advice remark codes, that are reported in the ASC X12 835. MACs do not need to re-edit codes or other data validated during the claim adjudication process during this back end validation. Valid codes are to be used in the flat file, unless:

- A service is being denied or rejected using an ASC X12 835 for submission of an invalid code, in which case the invalid code must be reported on the ASC X12 835;

- A code was valid when received, but was discontinued by the time the ASC X12 835 is issued, in which case, the received code must be reported on the ASC X12 835; or

- A code is received on a paper claim, and does not meet the required data attribute(s) for the HIPAA compliant ASC X12 835, in which case, "gap filling" would be needed if it were to be inserted in a compliant ASC X12 835.

Additionally A/B MACs and Common Electronic Data Interchange (CEDI) for DME MACs must follow the CMS instructions for Receipt, Control, and Balancing.

## 40.4 - Medicare Standard Electronic PC-Print Software for Institutional Providers

***(Rev.3288, Issued: 07-02-15, Effective: 08-03-15, Implementation: 08-03-15)***

*The* PC Print software enables institutional providers to print remittance data transmitted by Medicare. A/B MACs (A) are required to make PC Print software available to providers for downloading at no charge. A/B MACs (A) may charge up to $25 per mailing to recoup *costs* if the software is sent to *providers* on a CD/DVD or any other means at *the* provider's request when the software is available for downloading. This software must include self-explanatory loading and use information for providers. It should not be necessary to furnish provider training for use of PC Print software. A/B MACs (A) must supply providers with PC Print software within *3* weeks of request. The A/B MAC (A) Shared System (FISS) maintainer will supply PC Print software and a user's guide for all A/B MACs (A). The FISS maintainer must assure that the PC Print software is modified as needed to correspond to updates in the ERA and SPR formats per CMS instruction.

Providers are responsible for any telecommunication costs associated with receipt of the ASC X12 835, but the software itself can be downloaded at no cost.

The PC Print software enables providers to:

- *Allow the translation of the* ASC X12 835 electronic remittance advice *to user friendly report that can be reprinted;*
- View and print remittance information on all claims included in the ASC X12 835;
- View and print remittance information for a single claim;
- View and print a summary of claims billed for each Type of Bill (TOB) processed on this ERA; *and*
- View and print a summary of provider payments.

The receiving PC always writes an ASC X12 835 file in ASCII. The providers may choose one or more print options, e.g., the entire transmission, a single claim, a summary by bill type, or a provider payment summary. If software malfunctions are detected, they are to be corrected through the FISS maintainer. Individual A/B MACs (A) or data centers may not modify the PC Print software.

The software will also print the *CAQH* CORE defined business scenarios along with the texts for Claim Adjustment Reason and Remittance Advice Remark Codes reported on the 835 to explain any adjustment.

## 40.5 - Medicare Remit Easy Print Software for Professional Providers and Suppliers

***(Rev.3288, Issued: 07-02-15, Effective: 08-03-15, Implementation: 08-03-15)***

*The* CMS has developed software that gives professional providers/suppliers a tool to view and print an ERA in a human readable format. This software is called Medicare Remit Easy Print (MREP). It has been developed in response to comments that CMS has received from the provider/supplier community demonstrating a need for paper documents to reconcile accounts and facilitate claim submission to secondary/tertiary

payers. This software became available on October 11, 2005, to the providers through their respective A/B MACs and CEDI. The software is scheduled to be updated three times a year to accommodate the Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) tri-annual updates and any applicable enhancements. In addition to these three regular updates, there is also an annual enhancement update, if needed.

The MREP software enables providers to:

- View and print remittance information on all claims included in the ASC X12 835;
- View and print remittance information for a single claim;
- View and print a summary page; *and*
- View, print, and export special reports.

This software can be downloaded free of cost, but A/B MACs and CEDI may charge up to $25 per mailing to recoup *costs* if the software is sent to *providers* on a CD/DVD or any other means at *the* provider's request when the software is available for downloading. MREP software has been updated to accommodate ASC X12 835 version 5010.

The software will also print the *CAQH* CORE defined business scenarios along with the texts for Claim Adjustment Reason and Remittance Advice Remark Codes reported on the 835 to explain any adjustment.

## 50 - Standard Paper Remittance Advice

***(Rev.3288, Issued: 07-02-15, Effective: 08-03-15, Implementation: 08-03-15)***

The Standard Paper Remittance (SPR) is the hard copy version of an ERA. All A/B MACs and DME MACs must be capable of producing SPRs for providers who are unable or choose not to receive an ERA. A/B MACs and DME MACs suppress distribution of SPRs if a provider is also receiving ERAs for more than 31 days (institutional providers) or 45 days (professional providers/suppliers) respectively.

## 60.2 – Claim Adjustment Reason Codes

***(Rev.3288, Issued: 07-02-15, Effective: 08-03-15, Implementation: 08-03-15)***

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. MACs shall use only 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 ASC X12 835 structures only allow 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 claim adjustment reason codes:

- Can the information be conveyed by the use or modification of an existing reason code?
- Is the information available elsewhere in the ASC X12 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 ASC X12 trimester meeting in the months of January/February, June, and September/October. MACs 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 the Recurring Code Update Change Requests (CRs) or any other CMS instruction and/or downloading the list from the WPC website 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 website 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 website.

*The* MACs 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 ASC X12 835 reason or remark code might be mapped to one or more shared system codes, or vice versa, making it difficult for a MAC 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 MAC 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 MAC 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 ASC X12 835 version 4010 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 CMS 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. MACs 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. Some CARCs are so generic that the reason for adjustment cannot be communicated clearly without at least one remark code. These CARCs have a note added to the text for identification. A/B MACs and DME MACs must use at least one appropriate remark code when using one of these CARCs.

## 60.3 – Remittance Advice Remark Codes

***(Rev.3288, Issued: 07-02-15, Effective: 08-03-15, Implementation: 08-03-15)***

Remittance Advice Remark Codes (*RARCs*) 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. MACs must report appropriate remark code(s) that apply. There is another type of remark codes that does not add supplemental explanation for a specific adjustment but *provides* general adjudication information. These "Informational" remark codes start with the word "Alert" and can be reported without Group and Claim Adjustment Reason Code. An example of an "Informational" RARC would be:

> MA01: Alert: If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the appeal. However, in order to be eligible for an appeal, you must write to us within 120 days of the date you received this notice, unless you have a good reason for being late.

Remark codes at the service line level must be reported in the ASC X12 835 LQ segment. Remark codes that apply to an entire claim must be reported in either an ASC X12 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 MACs can actually report.

The remark code list is updated three times a year, and the list *is* posted at the WPC website and gets updated at the same time when the reason code list is updated. Both code lists are updated on or around March 1, July 1, and November 1. MACs must use the latest approved remark codes as included in the Recurring Code Update CR or any other CMS instruction or downloading the list from the WPC website after each update. MAC 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.

## 60.4 - Requests for Additional Codes

***(Rev.3288, Issued: 07-02-15, Effective: 08-03-15, Implementation: 08-03-15)***

The CMS has *a* national responsibility for maintenance of the remittance advice remark codes, and the Claim Adjustment Status Code Maintenance Committee maintains the claim adjustment reason codes. Requests for new or modification or deactivation of RARCs and CARCs should be sent to a mail box set up by CMS:

Remittance_Advice@CMS.HHS.GOV

*The* MACs should send their requests to this mail box for any change in CARC, RARC or any code combination. Requests for codes must include the suggested wording for the new or revised message, and an explanation of how the message will be used and why it is needed or *a* justification for the request.

To provide a summary of changes introduced in the previous *4* months, a code update instruction in the form of a CR is issued. These CRs will establish the deadline for Medicare shared system and MAC changes to complete the reason and/or remark code updates that had not already been implemented as part of a previous Medicare policy change instruction.

## 80 – *The Council for Affordable Quality Healthcare (*CAQH*) Committee on Operating Rules for Information Exchange (*CORE*)* Mandated Operating Rules

***(Rev.3288, Issued: 07-02-15, Effective: 08-03-15, Implementation: 08-03-15)***

Section 1104 of the Patient Protection and Affordable Care Act (ACA) establishes the development and implementation of "requirements for administrative transactions that will improve the utility of the existing HIPAA transactions and reduce administrative costs." A/B MACs/ CEDI/ and DME MACs are required to conform to the following CAQH Core Operating Rules impacting the transmittals of X12 835 transactions.

A complete list of ACA mandated operating rules are available at*:*
http://www.caqh.org/ORMandate_index.php.

## 80.1 - Health Care Claim Payment/Advice (835) Infrastructure Rule

***(Rev.3288, Issued: 07-02-15, Effective: 08-03-15, Implementation: 08-03-15)***

This operating rule regulates the transmission of batch 835 transactions including the exchange of security identifiers and communications-level acknowledgments and *errors*. This rule does not address the content of 835 communications beyond those required by the HIPAA mandated ASC X12 format. This rule designates a standard form of communication to ensure trading partner support by all A/B MACs, DME MACs, and CEDI contractors.

A complete list of requirements and technical direction for the Connectivity Rule are available at:
http://www.caqh.org/ORMandate_EFT.php

## 80.2 - Uniform Use of CARCs and RARCs Rule

***(Rev.3288, Issued: 07-02-15, Effective: 08-03-15, Implementation: 08-03-15)***

The CAQH CORE mandated operating rules require the usage of a standardized CARC and RARC combinations when used on the ASC X12 835 transactions. These combinations are maintained in a list updated *three* times a year by CAQH CORE.

The complete CARC/RARC code combination list is available at:
http://www.caqh.org/CORECodeCombinations.php

*The* MACs *may submit to CMS a request for modification to an existing code combination or a request to create a new code combination to the CAQH CORE Code Combination List. MACs may also request modifications, additions, or deletions of individual CARC and RARC codes to CMS. Requests are to be submitted to: Remittance_Advice@CMS.HHS.GOV.*

*All requests must include business justifications and contain, when available, reference to CMS instruction for the requested action.*

## 80.3 - EFT Enrollment Data Rule

***(Rev.3288, Issued: 07-02-15, Effective: 08-03-15, Implementation: 08-03-15)***

*The* CAQH CORE mandated operating rules establish standards for the enrollment of providers to electronic funds transfer (EFT) programs. The rule mandates the required data elements and the order in which they appear *on the* EFT enrollment forms. The rule also mandates acceptable EFT enrollment submission formats.

A complete list of required data elements and submission formats are available at*:*
http://www.caqh.org/Host/CORE/EFT-ERA/EFT_Enrollment_Data_Rule.pdf

## 80.4 - ERA Enrollment Form

***(Rev.3288, Issued: 07-02-15, Effective: 08-03-15, Implementation: 08-03-15)***

*The* CAQH CORE mandated operating rules establish standards for the enrollment of providers to ERA programs. The rule mandates the required data elements and the order in which they appear *on the* ERA enrollment forms. The rule also mandates acceptable EFT enrollment submission formats.

A complete list of required data elements and submission formats are available at*:*
http://www.caqh.org/Host/CORE/EFT-ERA/ERA_Enrollment_Data_Rule.pdf.