CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2442	**Date: April 6, 2012**
	Change Request 7775

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

I. SUMMARY OF CHANGES: This Change Request (CR) instructs the MACs and the Shared Systems to implement changes in CARCs and RARCs. This CR also instructs FISS and VIPs to update PC Print and MREP, respectively. The attached Recurring Update Notification applies to Chapter 22, sections 40.5, 60,1 and 60.2.

EFFECTIVE DATE: July 1, 2012
IMPLEMENTATION DATE: July 2, 2012

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

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

IV. ATTACHMENTS:

Recurring Update Notification
Unless otherwise specified, the effective date is the date of service.

Attachment – Recurring Update Notification

Pub. 100-04	Transmittal: 2442	Date: April 6, 2012	Change Request: 7775

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

Effective Date: July 1, 2012
Implementation Date: July 2, 2012

1. 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) and appropriate Remittance Advice Remark Codes (RARCs) that provide either supplemental explanation for a monetary adjustment or policy information that generally applies to the monetary adjustment are required in the remittance advice and coordination of benefits transactions.

The CARC and RARC changes that impact Medicare are usually requested by CMS staff in conjunction with a policy change. Contractors and Shared System Maintainers (SSMs) are notified about these changes in the corresponding instructions from the specific CMS component that implements the policy change, in addition to the regular code update notification. If a modification has been initiated by an entity other than CMS for a code currently used by Medicare, contractors must either use the modified code or another code if the modification makes the modified code inappropriate to explain the specific reason for adjustment. **SSMs have the responsibility to implement code deactivation making sure that any deactivated code is not used in original business messages, but the deactivated code in derivative messages is allowed. SSMs must make sure that Medicare does not report any deactivated code on or before the effective date for deactivation as posted on the WPC Web site.** Contractors shall stop using codes that have been deactivated on or **before** the effective date specified in the comment section (as posted on the WPC Web site) if they are currently being used. In order to comply with any deactivation, Medicare may have to stop using the deactivated code in original business messages **before** the actual "Stop Date" posted on the WPC Web site because the code list is updated three times a year, around March 1, July 1, and November 1 and may not align with the Medicare release schedule. Note that a deactivated code used in derivative messages must be accepted even after the code is deactivated if the deactivated code was used before the deactivation date by a payer or payers who adjudicated the claim before Medicare. Medicare contractors must stop using any deactivated reason and/or remark code past the deactivation date whether the deactivation is requested by Medicare or any other entity. **The regular code update Change Request (CR) will establish the implementation date for all modifications, deactivations, and any new code for Medicare contractors and the SSMs (see the table below for exceptions). If another specific CR has been issued by another CMS component with a different implementation date, the earlier of the two dates will apply for Medicare implementation**. If any new or modified code has an effective date past the implementation date specified in this CR, contractors must implement on the date specified on the WPC Web site.

See below for code change implementation exceptions if the implementation date in this recurring CR (or any other CMS CR) does not match the effective date specified at WPC Web site:

Type of Change	Implementation Date	Responsible Party
Deactivation	On or before the date posted at WPC Web site	SSMs
Modification	On the date posted at WPC Web site	Contractors/SSMs
New	On or after the date posted at WPC Web site	Contractors/SSMs

The discrepancy between the dates may arise because the WPC Web site gets updated only 3 times a year and may not match the CMS release schedule. This recurring CR lists only the changes that have been approved since the last code update CR (CR 7683, Transmittal 2372, issued on December 22, 2011), and does not provide a complete list of codes for these two code sets. Contractors must get the complete list for both CARC and RARC from the WPC Web site that is updated three times a year – around March 1, July 1, and November 1 – to get the comprehensive lists for both code sets. The implementation date for any new or modified or deactivated code for Medicare contractors is established by this recurring code update CR published three or four times a year according to the Medicare release schedule (see above for exception).

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

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

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

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

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

Claim Adjustment Reason Code (CARC):

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

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

The following new Claim Adjustment Reason Codes were approved by the Code Committee in January, and must be implemented, if appropriate, by July 2, 2012.

New Codes – CARC:

None

Modified Codes – CARC:

Code	Modified Narrative	Effective Date
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	11/1/2012
239	Claim spans eligible and ineligible periods of coverage. Rebill separate claims.	11/1/2012

Deactivated Codes – CARC:

None

Remittance Advice Remark Codes (RARC):

CMS is the national maintainer of the remittance advice remark code list. This code list is used by reference in the ASC X12 N transaction 835 (Health Care Claim Payment/Advice) and ASC X12N 837 COB (Health Care Claim) Implementation Guide (IG)/Technical Report (TR) 3. Under HIPAA, all payers, including Medicare, must use reason and remark codes approved by X12 recognized code set maintainers instead of proprietary codes to explain any adjustment in the claim payment. CMS as the X12 recognized maintainer of RARCs receives requests from Medicare and non-Medicare entities for new codes and modification/deactivation of existing codes. Additions, deletions, and modifications to the code list resulting from non-Medicare requests may or may not impact Medicare. Remark and reason code changes that impact Medicare are usually requested by CMS staff in conjunction with a policy change. Contractors are notified about these changes in the corresponding Change Requests from specific CMS components that implement those policy changes, in addition to the regular code update notification. If a modification has been initiated by an entity other than CMS for a code currently used by Medicare, contractors must use the modified code even though the modification was not initiated by Medicare or use another code if the modified code no longer explains the adjustment. Shared System Maintainers have the responsibility to implement code (both CARC and RARC) deactivation making sure that any deactivated code is not used in original business messages, but the deactivated code in derivative messages is allowed. The complete list of remark codes is available at: **http://www.wpc-edi.com/Reference**

RARC list is updated three times a year – in early March, July and November although the RARC Committee meets every month. The RARC Committee has established the following schedule:

Requests received in October – January:
Published in early March.
Deactivation becomes effective in October
Any new code or modification become effective when published

Request received in February – May:
Published in early July
Deactivation becomes effective in January

Any new code or modification become effective when published

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

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

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

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

By July 2, 2012, contractors must complete entry of all applicable code text changes and new codes, and the SSMs shall implement all code deactivations, if any. Note that deactivation decisions made earlier and included in earlier CRs may become effective now – consult the complete lists posted at WPC Web site to make sure that no deactivated code is reported on the 835 or Standard Paper Remittance (SPR) advice. Contractors must use the latest approved and valid Claim Adjustment Reason Codes and Remittance Advice Remark Codes in the 835 and corresponding SPR, and in the 837 COB.

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

New Codes – RARC:

Code	Code Narrative	Effective Date
N547	A refund request (Frequency Type Code 8) was processed previously.	3/6/2012
N548	Alert: Patient's calendar year deductible has been met.	3/6/2012
N549	Alert: Patient's calendar year out-of-pocket maximum has been met.	3/6/2012
N550	Alert: You have not responded to requests to revalidate your provider/supplier enrollment information. Your failure to revalidate your enrollment information will result in a payment hold in the near future.	3/6/2012
N551	Payment adjusted based on the Ambulatory Surgical Center (ASC) Quality Reporting Program.	3/6/2012
N552	Payment adjusted to reverse a previous withhold/bonus amount.	3/6/2012
N553	Payment adjusted based on a Low Income Subsidy (LIS) retroactive coverage or status change.	3/6/2012

Modified Codes – RARC:

Code	Modified Narrative	Effective Date
N4	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.	3/6/2012
N206	The supporting documentation does not match the information sent on the claim.	3/6/2012

Deactivated Codes – RARC:

None

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

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7775.1	Contractors shall update reason and remark codes that have been modified and apply to Medicare by July 2, 2012. **NOTE:** Some modifications may become effective at a future date. Contractors shall make sure that modifications are implemented **on the effective date as posted on the WPC Web site** (which may be later than the implementation date mentioned in this CR) for those code modifications that are being used by Medicare.	X	X	X	X	X					
7775.2	Contractors shall update reason and remark codes to include new codes that apply to Medicare by July 2, 2012,	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	
	or after July 2, 2012 if and as instructed by CMS. **NOTE:** Some new codes may become effective at a future date. Contractors shall make sure that new codes are implemented, if directed by CMS, **on the effective date or later as posted on the WPC Web site.**										
7775.3	FISS, MCS, and VMS shall make necessary programming changes so that no deactivated reason and remark code is reported in the remittance advice and no deactivated reason code is reported in the COB claim by April 2, 2012. **NOTE:** Check the updated lists as posted on the WPC Web site to capture deactivations that were included in previous CR(s).						X	X	X		
7775.4	FISS, MCS, VMS shall update any crosswalk between the standard reason and remark codes and the shared system internal codes provided to the contractors and make any standard code deactivated since the last update unavailable for use by the contractor by July 2, 2012.						X	X	X		
7775.5	FISS, MCS, CEDI shall make necessary programming changes so that deactivated reason and remark codes are allowed in derivative messages after the deactivation implementation date per this CR or as posted on the WPC Web site when: • Medicare is not primary; • The COB claims is received after the deactivation effective date; and • The date in DTP03 in Loop 2430 or 2330B in COB 837 transaction is less than the deactivation effective date as posted on the WPC Web site.						X	X			CEDI
7775.6	FISS, MCS, and VMS shall make necessary programming changes so that deactivated reason and remark codes are allowed even after the deactivation implementation date in a Reversal and Correction situation when a value of 22 in CLP02 identifies the claim to be a corrected claim.						X	X	X		
7775.7	VMS shall update the Medicare Remit Easy Print (MREP) software by July 2, 2012. This update shall be based on the CARC and RARC lists as posted on WPC Web site on March 6, 2012.								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	
	NOTE: This update is provided in a separate file since April 2008.										
7775.8	FISS shall update the PC Print software by July 2, 2012. This update shall be based on the CARC and RARC lists as posted on WPC Web site on March 6, 2012.						X				
7775.9	A/B MACs, carriers, and CEDI for DME MACs shall notify the users that the code update file must be downloaded to be used in conjunction with the updated MREP/PC Print software.	X			X						CEDI

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	
7775.10	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					CEDI

IV. SUPPORTING INFORMATION

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

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

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

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

VI. FUNDING

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

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

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

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