DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

Medicare Learning Network® MLN Matters® CMS
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- ICD-10-CM/PCS Billing and Payment Frequently Asked Questions, Fact Sheet (ICN 908974)

MLN Matters® Number: MM9278 Revised

Related CR Release Date: August 6, 2015

Related Transmittal #: R3298CP

Change Request (CR) #: CR 9278

Effective Date: October 1, 2015

Implementation Date: October 5, 2015

Remittance Advice Remark and Claims Adjustment Reason Code and Medicare Remit Easy Print and PC Print Update

Note: This article was revised on October 13, 2015, to correct a code in the Modified Codes – RARC table on pages 3-4. The code of N109 is now shown in that table, instead of the incorrect code of M109. All other information remains the same.

Provider Types Affected

This MLN Matters® Article is intended for providers who submit claims to Medicare Administrative Contractors (MACs), including Home Health and Hospice MACs (HHH MACs), and Durable Medical Equipment MACS (DME MACs) for services provided to Medicare beneficiaries.

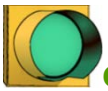
Provider Action Needed

STOP – Impact to You

If you do not have a valid, current, Clinical Laboratory Improvement Amendments of 1998 (CLIA) certificate and submit a claim to your MAC for a Current Procedural Terminology (CPT) code that is considered to be a laboratory test requiring a CLIA certificate, your Medicare payment may be impacted.

CAUTION – What You Need to Know

Change Request (CR) 9278 updates the Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) lists and also instructs Medicare system maintainers to update Medicare Remit Easy Print (MREP) and PC Print software used by some providers.



GO – What You Need to Do

Make sure that your billing staffs are aware of these updates.

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 staff of the Centers for Medicare & Medicaid Services (CMS), in conjunction with a policy change. MACs 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, MACs must either use the modified code or another code if the modification makes the modified code inappropriate to explain the specific reason for adjustment. If any new or modified code has an effective date past the implementation date specified in CR9278, MACs must implement on the effective date found at the WPC website.

The discrepancy between the dates may arise because the Washington Publishing Company (WPC) website gets updated only three times per year and may not match the CMS release

schedule. CR9278 lists only the changes that have been approved since the last code update by **CR9125**, issued on April 13, 2015, and does not provide a complete list of codes for these two code sets.

The WPC website has four listings available for both CARC and RARC. Those listings are available at **http://www.wpc-edi.com/Reference** on the WPC website.

Changes in RARC List Since CR9125

New Codes – RARC

Code	Modified Narrative	Effective Date
N753	Missing/Incomplete/Invalid Attachment Control Number.	07/01/2015
N754	Missing/Incomplete/Invalid Referring Provider or Other Source Qualifier on the 1500 Claim Form.	07/01/2015
N755	Missing/Incomplete/Invalid ICD Indicator on the 1500 Claim Form.	07/01/2015
N756	Missing/Incomplete/Invalid point of drop-off address,	07/01/2015
N757	Adjusted based on the Federal Indian Fees schedule (MLR).	07/01/2015
N758	Adjusted based on the prior authorization decision.	07/01/2015
N759	Payment adjusted based on the National Electrical Manufacturers Association (NEMA) Standard XR-29-2013.	07/01/2015

Modified Codes – RARC

Code	Modified Narrative	Effective Date
M47	Missing/Incomplete/Invalid Payer Claim Control Number. Other terms exist for this element including, but not limited to, Internal Control Number (ICN), Claim Control Number (CCN), Document Control Number (DCN).	07/01/2015
MA74	ALERT: This payment replaces an earlier payment for this claim that was either lost, damaged or returned.	07/01/2015
N432	ALERT: Adjustment based on a Recovery Audit.	07/01/2015
N22	ALERT: This procedure code was added/changed because it more accurately describes the services rendered.	07/01/2015

Code	Modified Narrative	Effective Date
M39	ALERT: The patient is not liable for payment of this service as the advance notice of non-coverage you provided the patient did not comply with program requirements.	07/01/2015
N109	ALERT: This claim/service was chosen for complex review.	07/01/2015
M38	ALERT: The patient is liable for the charges for this service as they were informed in writing before the service was furnished that we would not pay for it and the patient agreed to be responsible for the charges.	07/01/2015
N381	ALERT: Consult our contractual agreement for restrictions/billing/payment information related to these charges.	07/01/2015
MA91	ALERT: This determination is the result of the appeal you filed.	07/01/2015

Deactivated Codes - RARC

Code	Current Narrative	Effective Date
N102	This claim has been denied without reviewing the medical/dental record because the requested records were not received or were not received timely.	07/01/2016

***N735- This RARC is not included in the list of deactivated codes because CMS did not add this code during the previous release when it was included on the WPC website. The RARC was previously added to the WPC website erroneously.**

Changes in CARC List Since CR9125

New Code – CARC

Code	Modified Narrative	Effective Date
270	Claim received by the medical plan, but benefits not available under this plan. Submit these services to the patient's dental plan for further consideration.	07/01/2015

Modified Code – CARC

Code	Modified Narrative	Effective Date
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Note: This must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability.)	11/01/2015

There have been no **deactivated** CARC codes since CR9125.

In case of any discrepancy in the code text as posted on the WPC website and as reported in any CR, the WPC version should be implemented.

Additional Information

The official instruction, CR9278, issued to your MAC regarding this change is available at **http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3298CP.pdf** on the CMS website.

If you have any questions, please contact your MAC at their toll-free number. That number is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html** under "How Does It Work" on the CMS website.