CMS Manual System

Pub. 100-04 Medicare Claims Processing

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 436 **Date: JANUARY 21, 2005**

CHANGE REQUEST 3636

SUBJECT: **Remittance Advice Remark Code and Claim Adjustment Reason Code Update**

I. SUMMARY OF CHANGES: This contains information about reason and remark code changes approved from July 2004 through October 2004. Medicare contractors must update their remittance advice maps/matrices as appropriate to incorporate those changes that impact their electronic and paper remittance advice, and coordination of benefits transactions.

NEW/REVISED MATERIAL - EFFECTIVE DATE*: April 1, 2005
IMPLEMENTATION DATE: April 4, 2005

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. 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 not updated.*)
(R = REVISED, N = NEW, D = DELETED)

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

III. FUNDING: Medicare contractors shall implement these instructions within their current operating budgets.

IV. ATTACHMENTS:

	Business Requirements
	Manual Instruction
	Confidential Requirements
	One-Time Notification
X	**Recurring Update Notification**

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

Attachment – Recurring Update Notification

Pub. 100-04	Transmittal: 436	Date: January 21, 2005	Change Request 3636

SUBJECT: Remittance Advice Remark Code and Claim Adjustment Reason Code Update

I. GENERAL INFORMATION

A. Background: Per the Health Insurance Portability and Accountability Act (HIPAA) of 1996, health plans must be able to conduct standard electronic transactions for transactions listed in the implementing regulation using valid standard codes. Claim Adjustment Reason Codes and Remittance Advice Remark Codes are required for use in remittance advice and coordination of benefit (COB) transactions.

X12N 835 Health Care Remittance Advice Remark Codes

CMS is the national maintainer of the remittance advice remark code list, one of the code lists included in the ASC X12 835 (Health Care Claim Payment/Advice) and 837 (Health Care Claim, including COB)version 4010A1 Implementation Guides (IG). Under HIPAA, all payers, including Medicare, are required to use reason and remark codes approved by X12 recognized code set maintainers rather than local proprietary codes to explain adjustments in payment. As the X12 recognized maintainer of the Remittance Advice Remark Codes for the United States, CMS receives requests for codes that do not apply to Medicare, as well as code requests that do apply to Medicare. Not every remark code approved by CMS applies to Medicare.

Traditionally, remark codes that apply to Medicare are requested by CMS staff in conjunction with a Medicare policy change. Contractors are notified of approved new/modified codes that apply to Medicare in the implementation instructions for the individual policy change. New remark codes that apply to Medicare are also included in the full code update Change Requests (CR) such as this sent to Medicare contractors three times a year. If a modification has been initiated by an entity other than Medicare for a code currently used for Medicare business, Medicare contractors must use the modified code/message even if the modification was not initiated by Medicare and was not published in a Medicare policy instruction. If a new or modified code in a remittance advice code update CR is not initiated for Medicare, was not previously used for Medicare business, and CMS has not issued an instruction specifying use of the new or modified code/message, Medicare contractors are not required to begin use of that new/modified code/message. If a pre-existing code is deactivated (noted in the comments section of the listing), that has been used for Medicare business, Medicare contractors must stop using the code on or before the specified effective date of the deactivation. A complete list of all remark codes is available at: http://www.wpc-edi.com/codes **(Note that there has been a change in this Web address.)**

(**NOTE**: If you find any discrepancy between any code text included in this CR and the corresponding text as posted on the Washington Publishing Company (WPC) Web site, use the text posted at the Web site.)

By April 4, 2005, Medicare contractors must completed entry of all applicable code text changes and new codes, and terminated use of codes that are no longer active. Medicare contractors must use the latest approved and valid codes in their 835 and COB transactions, as well as in their standard paper remittance advice notices. The following lists summarize changes approved between July 2004 and October 2004.

New Code	Current Narrative	Medicare Initiated
N246	State regulated patient payment limitations apply to this service.	N
N247	Missing/incomplete/invalid assistant surgeon taxonomy.	Y
N248	Missing/incomplete/invalid assistant surgeon name.	Y
N249	Missing/incomplete/invalid assistant surgeon primary identifier.	Y
N250	Missing/incomplete/invalid assistant surgeon secondary identifier.	Y
N251	Missing/incomplete/invalid assistant attending physician taxonomy.	Y
N252	Missing/incomplete/invalid attending provider name.	Y
N253	Missing/incomplete/invalid attending provider primary identifier.	Y
N254	Missing/incomplete/invalid attending provider secondary identifier.	Y
N255	Missing/incomplete/invalid billing provider taxonomy.	Y
N256	Missing/incomplete/invalid billing provider/supplier name.	Y
N257	Missing/incomplete/invalid billing provider/supplier primary identifier.	Y
N258	Missing/incomplete/invalid billing provider/supplier address.	Y
N259	Missing/incomplete/invalid billing provider/supplier secondary identifier.	Y
N260	Missing/incomplete/invalid billing provider/supplier contact information.	Y
N261	Missing/incomplete/invalid operating provider name.	Y
N262	Missing/incomplete/invalid operating provider primary identifier.	Y
N263	Missing/incomplete/invalid operating provider secondary identifier.	Y
N264	Missing/incomplete/invalid ordering provider name.	Y
N265	Missing/incomplete/invalid ordering provider primary identifier.	Y
N266	Missing/incomplete/invalid ordering provider address.	Y
N267	Missing/incomplete/invalid ordering provider secondary identifier.	Y
N268	Missing/incomplete/invalid ordering provider contact information.	Y

N269	Missing/incomplete/invalid other provider name.	Y
N270	Missing/incomplete/invalid other provider primary identifier.	Y
N271	Missing/incomplete/invalid other provider secondary identifier.	Y
N272	Missing/incomplete/invalid other payer attending provider identifier.	Y
N273	Missing/incomplete/invalid other payer operating provider identifier.	Y
N274	Missing/incomplete/invalid other payer other provider identifier.	Y
N275	Missing/incomplete/invalid other payer purchased service provider identifier.	Y
N276	Missing/incomplete/invalid other payer referring provider identifier.	Y
N277	Missing/incomplete/invalid other payer rendering provider identifier.	Y
N278	Missing/incomplete/invalid other payer service facility provider identifier.	Y
N279	Missing/incomplete/invalid pay-to provider name.	Y
N280	Missing/incomplete/invalid pay-to provider primary identifier.	Y
N281	Missing/incomplete/invalid pay-to provider address.	Y
N282	Missing/incomplete/invalid pay-to provider secondary identifier.	Y
N283	Missing/incomplete/invalid purchased service provider identifier.	Y
N284	Missing/incomplete/invalid referring provider taxonomy.	Y
N285	Missing/incomplete/invalid referring provider name.	Y
N286	Missing/incomplete/invalid referring provider primary identifier.	Y
N287	Missing/incomplete/invalid referring provider secondary identifier.	Y
N288	Missing/incomplete/invalid rendering provider taxonomy.	Y
N289	Missing/incomplete/invalid rendering provider name.	Y
N290	Missing/incomplete/invalid rendering provider primary identifier.	Y
N291	Missing/incomplete/invalid rendering provider secondary identifier.	Y
N292	Missing/incomplete/invalid service facility name.	Y
N293	Missing/incomplete/invalid service facility primary identifier.	Y
N294	Missing/incomplete/invalid service facility primary address.	Y
N295	Missing/incomplete/invalid service facility secondary identifier.	Y

N296	Missing/incomplete/invalid supervising provider name.	Y
N297	Missing/incomplete/invalid supervising provider primary identifier.	Y
N298	Missing/incomplete/invalid supervising provider secondary identifier.	Y
N299	Missing/incomplete/invalid occurrence date(s).	Y
N300	Missing/incomplete/invalid occurrence span date(s).	Y
N301	Missing/incomplete/invalid procedure date(s).	Y
N302	Missing/incomplete/invalid other procedure date(s).	Y
N303	Missing/incomplete/invalid principal procedure.	Y
N304	Missing/incomplete/invalid dispensed date.	Y
N305	Missing/incomplete/invalid accident date.	Y
N306	Missing/incomplete/invalid acute manifestation date.	Y
N307	Missing/incomplete/invalid adjudication or payment date.	Y
N308	Missing/incomplete/invalid appliance placement date.	Y
N309	Missing/incomplete/invalid assessment date.	Y
N310	Missing/incomplete/invalid assumed or relinquished care date.	Y
N311	Missing/incomplete/invalid authorized to return to work date.	Y
N312	Missing/incomplete/invalid begin therapy date.	Y
N313	Missing/incomplete/invalid certification revision date.	Y
N314	Missing/incomplete/invalid diagnosis date.	Y
N315	Missing/incomplete/invalid disability from date.	Y
N316	Missing/incomplete/invalid disability to date.	Y
N317	Missing/incomplete/invalid discharge hour.	Y
N318	Missing/incomplete/invalid discharge or end of care date.	Y
N319	Missing/incomplete/invalid hearing or vision prescription date.	Y
N320	Missing/incomplete/invalid Home Health Certification Period.	Y
N321	Missing/incomplete/invalid last admission period.	Y
N322	Missing/incomplete/invalid last certification date.	Y

N323	Missing/incomplete/invalid last contact date.	Y
N324	Missing/incomplete/invalid last seen/visit date.	Y
N325	Missing/incomplete/invalid last worked date.	Y
N326	Missing/incomplete/invalid last x-ray date.	Y
N327	Missing/incomplete/invalid other insured birth date.	Y
N328	Missing/incomplete/invalid Oxygen Saturation Test date.	Y
N329	Missing/incomplete/invalid patient birth date.	Y
N330	Missing/incomplete/invalid patient death date.	Y
N331	Missing/incomplete/invalid physician order date.	Y
N332	Missing/incomplete/invalid prior hospital discharge date.	Y
N333	Missing/incomplete/invalid prior placement date.	Y
N334	Missing/incomplete/invalid reevaluation date.	Y
N335	Missing/incomplete/invalid referral date.	Y
N336	Missing/incomplete/invalid replacement date.	Y
N337	Missing/incomplete/invalid secondary diagnosis date.	Y
N338	Missing/incomplete/invalid shipped date.	Y
N339	Missing/incomplete/invalid similar illness or symptom date.	Y
N340	Missing/incomplete/invalid subscriber birth date.	Y
N341	Missing/incomplete/invalid surgery date.	Y
N342	Missing/incomplete/invalid test performed date.	Y
N343	Missing/incomplete/invalid Transcutaneous Electrical Nerve Stimulator (TENS) trial start date.	Y
N344	Missing/incomplete/invalid Transcutaneous Electrical Nerve Stimulator (TENS) trial end date.	Y

New codes from N247 to N344 have been created to replace a number of generic remark codes or to enable some existing codes to be split to better reflect their lowest component. This has been done to resolve some provider complaints that it is difficult for them to correlate certain remark codes with segments and data elements submitted on their corresponding claims. Codes with multiple meanings have been split, and new code(s) added to report each of multiple bits of information previously included in one message. For example:

1. M45 (Missing/incomplete/invalid occurrence codes or dates) has been modified to mean "Missing/incomplete/invalid occurrence code(s)," and N299 (Missing/incomplete/invalid occurrence date(s)) has been added to address the date portion of the prior message; and

2. MA29 has been deactivated entirely and codes N256, N258, N261, N264, N266, N269, N279, N281, N285, N289, N292, N294, and N296 have been added to convey distinct types of information all previously conveyed in MA29. (Since MA29 has been deactivated, this change has not been included in the "split from" listing below.)

In a departure from normal practice, the replacement codes are not listed in the comment section for this update due to their large number. Following is a list showing the new codes and the source code that has been modified/split to create the new code

New Code	**Split from Existing Code**
N299	M45
N300	M46
N301	M51
N302	M74
N303	MA66
N304	N57

Modified Remark Codes

Code	**Current Modified Narrative**	**Modification Date**
M67	Missing/incomplete/invalid other procedure code(s).	12/2/04
M74	This service does not qualify for a HPSA/Physician Scarcity bonus payment.	12/2/04
M45	Missing/incomplete/invalid occurrence code(s).	12/2/04
M46	Missing/incomplete/invalid occurrence span code(s).	12/2/04
M51	Missing/incomplete/invalid procedure code(s).	12/2/04
MA66	Missing/incomplete/invalid principal procedure code.	12/2/04
MA121	Missing/incomplete/invalid x-ray date.	12/2/04
MA122	Missing/incomplete/invalid initial treatment date.	12/2/04
N31	Missing/incomplete/invalid prescribing provider identifier.	12/2/04
N57	Missing/incomplete/invalid prescribing date.	12/2/04

Deactivated Remark Codes

Code	Current Narrative	Deactivation Date
M57	Missing/incomplete/invalid provider identifier.	6/2/05
M68	Missing/incomplete/invalid attending, ordering, rendering, supervising or referring physician identification.	6/2/05
M108	Missing/incomplete/invalid provider identifier for the provider who interpreted the diagnostic test.	6/2/05
M110	Missing/incomplete/invalid provider identifier for the provider from whom you purchased interpretation services.	6/2/05
M120	Missing/incomplete/invalid provider identifier for the substituting physician who furnished the service(s) under a reciprocal billing or locum tenens arrangement.	6/2/05
M128	Missing/incomplete/invalid date of the patient's last physician visit.	6/2/05
M128	Missing/incomplete/invalid provider name, city, state, or zip code.	6/2/05
MA29	Missing/incomplete/invalid provider name, city, state, or zip code.	6/2/05
MA38	Missing/incomplete/invalid birth date.	6/2/05
MA52	Missing/incomplete/invalid date.	6/2/05
MA82	Missing/incomplete/invalid provider/supplier billing number/identifier or billing name, address, city, state, zip code, or phone number.	6/2/05
MA105	Missing/incomplete/invalid provider number for this place of service.	6/2/05
MA127	Reserved for future use.	6/2/05
N145	Missing/incomplete/invalid provider identifier for this place of service.	6/2/05

Health Care Claim Adjustment Reason Codes

A national code committee, also recognized by X12, maintains the health care claim adjustment reason codes that are reported in X12 835 and 837 COB transactions, as well as in paper remittance advice notices issued for Medicare. The committee meets at the beginning of each X12 trimester meeting (February, June and October) and makes decisions about additions, modifications, and retirement of existing reason codes. The updated list is posted three times a year after each X12 trimester meeting at: http://wpc-edi.com/codes **(Note the change in this Web address.)**

All reason code changes approved in October 2004 are listed here. By April 4, 2005, you must have the most current reason code set installed for production use. All Medicare contractors must

use the latest approved reason codes in their 835, standard paper remittance advice, and COB transactions.

Most requests for reason code change(s) are submitted by non-Medicare entities. If Medicare requests a change, it would normally be included in an individual Medicare instruction on that topic, as well as be included in a full update, such as in this instruction, that is issued three times per year. These reason code updates provide a summary of changes in the reason codes introduced since the last update notification, and establish the deadline for Medicare contractors to implement the reason code changes that may not already have been implemented as part of a previous Medicare policy change instruction.

A reason code may be retired if it is considered to be obsolete or it is determined that its information can be conveyed through use of an alternate reason code. Code retirements are effective for a specified future implementation guide version and succeeding versions, but payers have the option to also discontinue use of retired codes in earlier versions of the 835 and 837 that may still be in use. Medicare contractors are to discontinue use of retired claim adjustment reason codes and messages in standard paper remittance advice notices effective with the same date use of retired codes is terminated for use in an 835 or 837. The committee approved only one reason code change in October 2004.

Code	Current Narrative	Notes
165	Payment denied/reduced for absence of, or exceeded referral.	New as of 10/04

B. Policy: Medicare contractors may not report claim adjustment reason codes or remark codes in their X12 835 and 837 COB transactions, or in their standard paper remittance advice notices, that are not valid as published at www-wpc-edi.com/codes for the date of issue and the electronic transaction version used. Reason and remark codes must be used as applicable to describe the reason for each payment adjustment reported in a remittance advice or COB transaction, as well as to convey appeal rights, and certain other information that applies to those services in a remittance advice. These code sets are updated by their maintainers on a regular basis and Medicare contractors must modify their usage of those codes that apply to Medicare business accordingly as updates are issued.

C. Provider Education: A Medlearn Matters provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn 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 1 week of the availability of the provider education article. In addition, the provider education article must be included in your next regularly scheduled bulletin. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

						Shared System Maintainers				Other
		FI	RHHI	Carrier	DMERC	FISS	MCS	VMS	CWF	
						FISS	MCS	VMS	CWF	
3636.1	Intermediaries/RHHIs/Carriers/DMERCs and VMS shall update remark codes that have been modified and which apply to Medicare by April 4, 2005.	X	X	X	X			X		
3636.2	Intermediaries/RHHIs/Carriers/DMERCs and VMS shall stop using any remark code that has been deactivated by April 4, 2005. (Not listed for MCS as this is controlled by the carriers.)	X	X	X	X	X		X		
3636.3	Intermediaries/RHHIs/Carriers/DMERCs, FISS and VMS shall add new reason and remark codes that are applicable to Medicare by April 4, 2005. (Action not required for MCS as code updates are controlled by the carriers.)	X	X	X	X	X		X		
3636.4	Intermediaries/RHHIs/Carriers/DMERCs shall furnish provider education about changes in claim adjustment reason and remittance advice remark codes. Contractors shall post the above mentioned medlearn article, or a direct link to the article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article must be included in your next regularly scheduled bulletin.	X	X	X	X					

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: April 1, 2005 **Implementation Date:** April 4, 2005 **Pre-Implementation Contact(s):** Sumita Sen, ssen@cms.hhs.gov 410-786-5755 **Post-Implementation Contact(s):** Sumita Sen, ssen@cms.hhs.gov 410-786-5755	**Medicare contractors shall implement these instructions within their current operating budgets.**

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