CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1345	**Date: SEPTEMBER 28, 2007**
	Change Request 5721

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

I. SUMMARY OF CHANGES: This Change Request (CR) instructs contractors and VIPs 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: October 1, 2007
Implementation Date: October 1, 2007

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:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2007 operating budgets.

IV. ATTACHMENTS:

Recurring Update Notification

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

Attachment – Recurring Update Notification

Pub. 100-04	Transmittal: 1345	Date: September 28, 2007	Change Request: 5721

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

Effective date: October 1, 2007

Implementation date: October 1, 2007

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. As the recognized maintainer of the RARC, CMS receives a significant number of requests for new remark codes and modifications in existing remark codes from Medicare and non-Medicare entities. Additions, deletions, and modifications to the code list resulting from non-Medicare requests may not impact Medicare. Recently, a number of entities requested new remark codes as a response to modification – a remark code must be used when using one of the following Claim Adjustment Reason Codes 16, 17, 96, 125, and A1. Contractors may pick one of those newly created remark codes for Medicare use, if appropriate.

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, which implement 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. 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. Medicare contractors shall not use any deactivated code past the deactivation date whether the deactivation is requested by Medicare or any other entity. The complete list of remark codes is available at: http://www.wpc-edi.com/codes

The list is updated 3 times a year. **Please note that in order to synchronize with the CARC update schedule, the RARC list will be updated in early November, March, and July instead of the current schedule of early December, April, and August.** By October 1, 2007, you must complete entry of all applicable code text changes and new codes, and terminate use of deactivated codes.

You must use the latest approved and valid codes in your 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. A list of the modified codes is provided later in this CR.

Remittance Advice Remark Code Changes

New Codes

Code	Current Narrative	Medicare Initiated
N380	The original claim has been processed, submit a corrected claim.	No
N381	Consult our contractual agreement for restrictions/billing/payment information related to these charges.	No
N382	Missing/incomplete/invalid patient identifier.	No
N383	Services deemed cosmetic are not covered	No
N384	Records indicate that the referenced body part/tooth has been removed in a previous procedure.	No
N385	Payment has been adjusted because notification of admission was not timely according to published plan procedures.	No

N386	This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at http://www.cms.hhs.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.	Yes
N387	You should submit this claim to the patient's other insurer for potential payment of supplemental benefits. We did not forward the claim information.	Yes

Modified Codes

The following codes have been identified as "Informational" codes, and modified to add the word "Alert" in front of the current text. If you feel that any of these "Informational" codes is being used to explain a specific adjustment as opposed to provide general information, please contact the author of this CR.

M4	MA15	N59	N155	N353
M6	MA18	N84	N156	N355
M9	MA19	N85	N162	N358
M17	MA26	N88	N177	N360
M27	MA28	N89	N183	N363
M32	MA44	N130	N185	N364
M39	MA45	N132	N187	N367
M70	MA59	N133	N189	
M118	MA62	N134	N196	
MA01	MA68	N136	N202	
MA07	MA72	N137	N210	
MA08	MA77	N138	N211	
MA10	N1	N139	N215	
MA13	N21	N140	N220	
MA14	N23	N154	N352	

Code MA08 text has been modified further.

Old text: You should also submit this claim to the patient's other insurer for potential payment of supplemental benefits. We did not forward the claim information as the supplemental coverage is not with a Medigap plan, or you do not participate in Medicare.

New Text**: Alert:** Claim information was not forwarded because the supplemental coverage is not with a Medigap plan, or you do not participate in Medicare.

Deactivated Codes

Code	Current Narrative	Notes
N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.	Deactivated effective 10/1/07. Consider using Reason Code 45

N361	Payment adjusted based on multiple diagnostic imaging procedure rules	Deactivated effective 10/1/07. Consider using Reason Code 59

X12 N 835 Health Care Claim Adjustment Reason Codes

A national code maintenance committee maintains the health care Claim Adjustment Reason Codes (RARCs). 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 after each X12 trimester meeting. To access the list select http://www.wpc-edi.com/codes. Select Claim Adjustment Reason Codes from the pull down menu. All reason code changes approved up to June 2007 are listed here. By October 1, 2007 you must have completed entry of all applicable code text changes and new codes, and terminated use of deactivated codes. You must use the latest approved and valid codes in your 835, corresponding standard paper remittance advice, and coordination of benefits transactions.

As mentioned earlier in CR 5634, at least one remark code must be used with the following 5 RARCs:

16: Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code).

17: Payment adjusted because 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).

96: Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

125: Payment adjusted due to a 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).

A1: Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code).

The request for a reason code change may come from either Medicare or non-Medicare entities. If Medicare requests a change, it may be included in a Medicare instruction in addition to this regular code update notification. The regular code update notification is issued on a regular periodic basis to provide a summary of changes in the reason and remark codes introduced since the last update notification, and will establish the deadline for Medicare contractors to implement the reason and remark code changes that may not already have been implemented as part of a previous Medicare policy change instruction.

The code committee has made some changes recently about the time line for deactivation and modification. Previously a reason code deactivation was IG version rather than date specific. Now a deactivated code will have a date specified – 6 months from posting – when it becomes invalid, and no longer be used in the remittance advice for original claim adjudication. Contractors can discontinue use of deactivated codes prior to the effective date (”stop date”), and are not allowed to use the deactivated code past the stop date. In June, the committee voted to introduce a 6 month lead time for modifications also. Now you have 6 months from the date of publication to implement the modification.

The regular code update notification will establish the deadline for deactivation and modification for Medicare contractors. The Medicare deadline could be earlier than the date specified in the Washington Publishing Company (WPC) posting. But other payers may continue using these deactivated and/or modified codes till the stop date. The definitions of Start Date, Last Modified Date, and Stop Date are:

Explanation of Start, Last Modified, and Stop

Start

Every code has a Start date. This is the date when the code was first available in the code list.

Last Modified

When populated, this is the date of the code list release when the definition of the specific code was last modified by the committee. This date represents a point when the definition changed from one wording to another.

Stop

When populated, this date identifies that the code can no longer be used in original business messages after that date. The code can only be used in derivative business messages (messages where the code is being reported from the original business message). For example, a Claim Adjustment Reason Code with a Stop date of 02/01/2007 would not be able to be used by a health plan in a CAS segment in a claim payment/remittance advice transaction (835) dated after 02/01/2007 as part of an original claim adjudication (CLP02 values like “1", ”2", “3" or ”19"). The code would still be able to be used after 02/01/2007 in derivative transactions, as long as the original usage was prior to 02/01/2007. Derivative transactions include: secondary or tertiary claims (837) from the provider or health plan to a secondary or tertiary health plan, an 835 from the original health plan to the provider as a reversal of the original adjudication (CLP02 value “22”). The deactivated code is usable in these derivative transactions because they are reporting on the valid usage (pre-deactivation) of the code in a previously generated 835 transaction.

The committee approved the following reason codes since the last code update CR 5456.

Reason Code Changes

New Codes

Code	Current Narrative	Notes
202	Payment adjusted due to non-covered personal comfort or convenience services.	Start: 02/28/2007
203	Payment adjusted for discontinued or reduced service.	Start: 02/28/2007
204	This service/equipment/drug is not covered under the patient’s current benefit plan	Start: 02/28/2007
205	Pharmacy discount card processing fee	Start: 07/09/2007

206	NPI denial - missing	Start: 07/09/2007
207	NPI denial - Invalid format	Start: 07/09/2007 | Stop: 05/23/2008
208	NPI denial - not matched	Start: 07/09/2007
209	Per regulatory or other agreement, the provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to patient if collected. (Use Group code OA)	Start: 07/09/2007
210	Payment adjusted because pre-certification/authorization not received in a timely fashion	Start: 07/09/2007
211	National Drug Codes (NDC) not eligible for rebate, are not covered.	Start: 07/09/2007

Modified Codes

Code	Current Narrative	Notes
59	Charges are adjusted based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.)	Start: 01/01/1995 | Last Modified: 02/28/2007
85	Interest amount. This change effective 1/1/2008: Patient Interest Adjustment (Use Only Group code PR) **NOTES**: Only use when the payment of interest is the responsibility of the patient.	Start: 01/01/1995 | Last Modified: 07/09/2007
115	Payment adjusted as procedure postponed or canceled. This change effective 1/1/2008: Payment adjusted as procedure postponed, canceled, or delayed.	Start: 01/01/1995 | Last Modified: 07/09/2007
197	Payment adjusted for absence of recertification/authorization. This change effective 1/1/2008: Payment adjusted for absence of precertification/authorization/notification.	Start: 10/31/2006 | Last Modified: 07/09/2007

Deactivated Codes

Code	Current Narrative	Notes
A2	Contractual adjustment. **NOTES**: Use Code 45 with Group Code 'CO' or use another appropriate specific adjustment code. The "Stop" date of 1/1/2008 may change.	Start: 01/01/1995 | Stop: **01/01/2008** | Last Modified: 02/28/2007
207	NPI denial - Invalid format	Start: 07/09/2007 | Stop: **05/23/2008**

The following is a comprehensive list of deactivated codes. These codes have been deactivated prior to publication of this CR and have been included in previous CRs. Because of a policy change, the deactivation date may have moved from a specific version to a specific date. Contractors shall not use any of these codes in any original business messages, but these codes may be used in derivative business messages (messages where the code is being reported from the original business message).

Comprehensive list of Deactivated Codes

Code	Current Narrative	Notes
28	Coverage not in effect at the time the service was provided. **NOTES**: Redundant to codes 26&27.	Start: 01/01/1995 | Stop: 10/16/2003
30	Payment adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.	Start: 01/01/1995 | Stop: 02/01/2006
36	Balance does not exceed co-payment amount.	Start: 01/01/1995 | Stop: 10/16/2003
37	Balance does not exceed deductible.	Start: 01/01/1995 | Stop: 10/16/2003
41	Discount agreed to in Preferred Provider contract.	Start: 01/01/1995 | Stop: 10/16/2003
42	Charges exceed our fee schedule or maximum allowable amount. (Use CARC 45)	Start: 01/01/1995 | Stop: 06/01/2007 | Last Modified: 10/31/2006
43	Gramm-Rudman reduction.	Start: 01/01/1995 | Stop: 07/01/2006
46	This (these) service(s) is (are) not covered. **NOTES**: Use code 96.	Start: 01/01/1995 | Stop: 10/16/2003
47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.	Start: 01/01/1995 | Stop: 02/01/2006
48	This (these) procedure(s) is (are) not covered. **NOTES**: Use code 96.	Start: 01/01/1995 | Stop: 10/16/2003
52	The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.	Start: 01/01/1995 | Stop: 02/01/2006
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. **NOTES**: Split into codes 150, 151, 152, 153 and 154.	Start: 01/01/1995 | Stop: 06/30/2007
62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.	Start: 01/01/1995 | Stop: 04/01/2007 | Last Modified: 10/31/2006
63	Correction to a prior claim.	Start: 01/01/1995 | Stop: 10/16/2003

64	Denial reversed per Medical Review.	Start: 01/01/1995 | Stop: 10/16/2003
65	Procedure code was incorrect. This payment reflects the correct code.	Start: 01/01/1995 | Stop: 10/16/2003
67	Denial reversed per Medical Review.	Start: 01/01/1995 | Stop: 10/16/2003
68	DRG weight. (Handled in CLP12)	Start: 01/01/1995 | Stop: 10/16/2003
71	Primary Payer amount. **NOTES**: Use code 23.	Start: 01/01/1995 | Stop: 06/30/2000
72	Coinsurance day. (Handled in QTY, QTY01=CD)	Start: 01/01/1995 | Stop: 10/16/2003
73	Administrative days.	Start: 01/01/1995 | Stop: 10/16/2003
77	Covered days. (Handled in QTY, QTY01=CA)	Start: 01/01/1995 | Stop: 10/16/2003
79	Cost Report days. (Handled in MIA15)	Start: 01/01/1995 | Stop: 10/16/2003
80	Outlier days. (Handled in QTY, QTY01=OU)	Start: 01/01/1995 | Stop: 10/16/2003
81	Discharges.	Start: 01/01/1995 | Stop: 10/16/2003
82	PIP days.	Start: 01/01/1995 | Stop: 10/16/2003
83	Total visits.	Start: 01/01/1995 | Stop: 10/16/2003
84	Capital Adjustment. (Handled in MIA)	Start: 01/01/1995 | Stop: 10/16/2003
86	Statutory Adjustment. Notes: Duplicative of code 45.	Start: 01/01/1995 | Stop: 10/16/2003
88	Adjustment amount represents collection against receivable created in prior overpayment.	Start: 01/01/1995 | Stop: 06/30/2007
92	Claim Paid in full.	Start: 01/01/1995 | Stop: 10/16/2003
93	No Claim level Adjustments. **NOTES**: As of 004010, CAS at the claim level is optional.	Start: 01/01/1995 | Stop: 10/16/2003
98	The hospital must file the Medicare claim for this inpatient non-physician service.	Start: 01/01/1995 | Stop: 10/16/2003
99	Medicare Secondary Payer Adjustment Amount.	Start: 01/01/1995 | Stop: 10/16/2003
113	Payment denied because service/procedure was provided outside the United States or as a result of war. **NOTES**: Use Codes 157, 158 or 159.	Start: 01/01/1995 | Stop: 06/30/2007 | Last Modified: 02/28/2001

120	Patient is covered by a managed care plan. **NOTES**: Use code 24.	Start: 01/01/1995 | Stop: 06/30/2007
123	Payer refund due to overpayment. **NOTES**: Refer to implementation guide for proper handling of reversals.	Start: 01/01/1995 | Stop: 06/30/2007
124	Payer refund amount - not our patient. **NOTES**: Refer to implementation guide for proper handling of reversals.	Start: 01/01/1995 | Stop: 06/30/2007 | Last Modified: 06/30/1999
196	Claim/service denied based on prior payer's coverage determination. **NOTES**: Use code 136.	Start: 06/30/2006 | Stop: 02/01/2007
A3	Medicare Secondary Payer liability met.	Start: 01/01/1995 | Stop: 10/16/2003
B2	Medicare Secondary Payer liability met.	Start: 01/01/1995 | Stop: 10/16/2003
B3	Covered charges.	Start: 01/01/1995 | Stop: 10/16/2003
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.	Start: 01/01/1995 | Stop: 02/01/2006
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.	Start: 01/01/1995 | Stop: 02/01/2006
B19	Claim/service adjusted because of the finding of a Review Organization.	Start: 01/01/1995 | Stop: 10/16/2003
B21	The charges were reduced because the service/care was partially furnished by another physician.	Start: 01/01/1995 | Stop: 10/16/2003
D1	Claim/service denied. Level of subluxation is missing or inadequate. **NOTES**: Use code 16 and remark codes if necessary.	Start: 01/01/1995 | Stop: 10/16/2003
D2	Claim lacks the name, strength, or dosage of the drug furnished. **NOTES**: Use code 16 and remark codes if necessary.	Start: 01/01/1995 | Stop: 10/16/2003
D3	Claim/service denied because information to indicate if the patient owns the equipment that requires the part or supply was missing. **NOTES**: Use code 16 and remark codes if necessary.	Start: 01/01/1995 | Stop: 10/16/2003

D4	Claim/service does not indicate the period of time for which this will be needed. **NOTES**: Use code 16 and remark codes if necessary.	Start: 01/01/1995 | Stop: 10/16/2003
D5	Claim/service denied. Claim lacks individual lab codes included in the test. **NOTES**: Use code 16 and remark codes if necessary.	Start: 01/01/1995 | Stop: 10/16/2003
D6	Claim/service denied. Claim did not include patient's medical record for the service. **NOTES**: Use code 16 and remark codes if necessary.	Start: 01/01/1995 | Stop: 10/16/2003
D7	Claim/service denied. Claim lacks date of patient's most recent physician visit. **NOTES**: Use code 16 and remark codes if necessary.	Start: 01/01/1995 | Stop: 10/16/2003
D8	Claim/service denied. Claim lacks indicator that `x-ray is available for review. **NOTES**: Use code 16 and remark codes if necessary.	Start: 01/01/1995 | Stop: 10/16/2003
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. **NOTES**: Use code 16 and remark codes if necessary.	Start: 01/01/1995 | Stop: 10/16/2003
D10	Claim/service denied. Completed physician financial relationship form not on file. **NOTES**: Use code 17.	Start: 01/01/1995 | Stop: 10/16/2003
D11	Claim lacks completed pacemaker registration form. **NOTES**: Use code 17.	Start: 01/01/1995 | Stop: 10/16/2003
D12	Claim/service denied. Claim does not identify who performed the purchased diagnostic test or the amount you were charged for the test. **NOTES**: Use code 17.	Start: 01/01/1995 | Stop: 10/16/2003
D13	Claim/service denied. Performed by a facility/supplier in which the ordering/referring physician has a financial interest. **NOTES**: Use code 17.	Start: 01/01/1995 | Stop: 10/16/2003
D14	Claim lacks indication that plan of treatment is on file. **NOTES**: Use code 17.	Start: 01/01/1995 | Stop: 10/16/2003
D15	Claim lacks indication that service was supervised or evaluated by a physician. **NOTES**: Use code 17.	Start: 01/01/1995 | Stop: 10/16/2003

D16	Claim lacks prior payer payment information. **NOTES**: Use code 16 with appropriate claim payment remark code [N4].	Start: 01/01/1995 | Stop: 06/30/2007
D17	Claim/Service has invalid non-covered days. **NOTES**: Use code 16 with appropriate claim payment remark code.	Start: 01/01/1995 | Stop: 06/30/2007
D18	Claim/Service has missing diagnosis information. **NOTES**: Use code 16 with appropriate claim payment remark code.	Start: 01/01/1995 | Stop: 06/30/2007
D19	Claim/Service lacks Physician/Operative or other supporting documentation **NOTES**: Use code 16 with appropriate claim payment remark code.	Start: 01/01/1995 | Stop: 06/30/2007
D20	Claim/Service missing service/product information. **NOTES**: Use code 16 with appropriate claim payment remark code.	Start: 01/01/1995 | Stop: 06/30/2007
D21	This (these) diagnosis(es) is (are) missing or are invalid	Start: 01/01/1995 | Stop: 06/30/2007

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 use only currently valid codes, and 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

"Shall" denotes a mandatory requirement
"Should" denotes an optional 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		
5721.1	A/B MACs, carriers, DME MACs, FIs, RHHIs, and VMS shall update reason and remark codes that have been modified and apply to Medicare by October 1, 2007.	X	X	X	X	X			X			
5721.2	A/B MACs, carriers, DME MACs, FIs, RHHIs and VMS	X	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 reason and remark codes to include new codes that apply to Medicare by October 1, 2007. .										
5721.3	A/B MACs, carriers, DME MACs, FIs, RHHIs and VMS shall update Reason and remark codes that have been deactivated whether they apply to Medicare or not by October 1, 2007.	X	X	X	X	X			X		
5721.4	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 January, 2007.)								X		
5721.5	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	
5721.6	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	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	
	would benefit their provider community in billing and administering the Medicare program correctly.										

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

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

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 and Carriers*, use only one of the following statements:
No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

B. *For Medicare Administrative Contractors (MACs)*, use the following statement:

The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). 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.