CMS Manual System

Pub. 100-04 Medicare Claims Processing

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

Transmittal 313 **Date: October 15, 2004**

CHANGE REQUEST 3466

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

I. SUMMARY OF CHANGES: This contains information about reason and remark code updates from March 2004 through June 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 (COB) transactions.

NEW/REVISED MATERIAL - EFFECTIVE DATE*: January 1, 2005
IMPLEMENTATION DATE: January 3, 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) – (*Only One Per Row.*)

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

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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 mentioned in the regulation using valid standardized codes. These two code sets (Claim Adjustment Reason Code and Remittance Advice Remark Code) are used in remittance advice and coordination of benefits transactions.

X12N 835 Health Care Remittance Advice Remark Codes

The CMS is the national maintainer of the remittance advice remark code list that is one of the code lists mentioned in the ASC X12 transaction 835 (Health Care Claim Payment/Advice) version 4010A1 Implementation Guide (IG). Under HIPAA, all payers, including Medicare, have to use reason and remark codes approved by X12 recognized maintainers instead of proprietary codes to explain any adjustment in the payment. Approved code changes requested by non-Medicare entities may not impact Medicare. Traditionally, Medicare staff in conjunction with a policy change, requests remark code changes that impact Medicare. Contractors are notified of those new/modified codes in the corresponding implementation 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 Medicare for a code currently used by Medicare, contractors must use the modified code even though the modification was not initiated by Medicare. If a new code is not initiated by Medicare, contractors do not have to use it unless otherwise instructed by Medicare. Contractors must stop using codes that have been deactivated on or before the effective date specified in the comment section if they are currently being used. The list is updated three times a year, and the complete list of remark codes is available at:
http://www.wpc-edi.com/codes/Codes.asp

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

By January 3, 2005, 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. The following list summarizes changes made from March 2004 to June 2004.

New Code	Current Narrative	Medicare Initiated
N217	We pay only one site of service per provider per claim.	Y
N218	You must furnish and service this item for as long as the patient continues to need it. We can pay for maintenance and/or servicing for the time period specified in the contract or coverage manual.	Y
N219	Payment based on previous payer's allowed amount.	N
N220	See the payer's web site or contact the payer's Customer Service department to obtain forms and instructions for filing a provider dispute.	N
N221	Missing Admitting History and Physical report.	N
N222	Incomplete/invalid Admitting History and Physical report.	N
N223	Missing documentation of benefit to the patient during initial treatment period.	N
N224	Incomplete/invalid documentation of benefit to the patient during initial treatment period.	N
N225	Incomplete/invalid documentation/orders/notes/summary/report/invoice.	Y
N226	Incomplete/invalid American Diabetes Association Certificate of Recognition.	Y
N227	Incomplete/invalid Certificate of Medical Necessity.	Y
N228	Incomplete/invalid consent form.	Y
N229	Incomplete/invalid contract indicator.	Y
N230	Incomplete/invalid indication of whether the patient owns the equipment that requires the part or supply.	Y
N231	Incomplete/invalid invoice or statement certifying the actual cost of the lens, less discounts, and/or the type of intraocular lens used.	Y
N232	Incomplete/invalid itemized bill.	Y
N233	Incomplete/invalid operative report.	Y
N234	Incomplete/invalid oxygen certification/re-certification.	Y
N235	Incomplete/invalid pacemaker registration form.	Y
N236	Incomplete/invalid pathology report.	Y
N237	Incomplete/invalid patient medical record for this service.	Y
N238	Incomplete/invalid physician certified plan of care.	Y
N239	Incomplete/invalid physician financial relationship form.	Y
N240	Incomplete/invalid radiology report.	Y
N241	Incomplete/invalid Review Organization Approval.	Y
N242	Incomplete/invalid x-ray.	Y

N243	Incomplete/invalid/not approved screening document.	Y
N244	Incomplete/invalid pre-operative photos/visual field results.	Y
N245	Incomplete/invalid plan information for other insurance.	Y

New codes from N225 to N245 have been created by splitting 21 existing codes to help automate provider action. The rationale for splitting these codes is that if a document is missing, the provider action would involve sending the document to Medicare. On the other hand if the document sent is incomplete/invalid, providers need to research and rectify before sending the corrected document to Medicare. This is a different action than just sending the missing document. Medicare contractors must use the new codes as appropriate in lieu of the existing codes. For example if the consent form is incomplete/invalid, use code N228, and N3 only if it is missing. Following is a list showing the new codes and the source code that has been split to create the new code:

New Code	Split from existing Code
N225	N29
N226	M142
N227	M60
N228	N3
N229	N190
N230	M124
N231	M130
N232	N26
N233	M29
N234	M19
N235	M132
N236	M30
N237	M127
N238	M141
N239	M131
N240	M31
N241	N175
N242	N40
N243	N146
N244	N178
N245	MA92

Modified Remark Codes

Code	Current Modified Narrative	Modification Date
M19	Missing oxygen certification/re-certification.	(Modified 8/1/04, 2/28/03) Also see N234 Modified eff. 4/1/04
M29	Missing operative report.	(Modified 8/1/04, 2/28/03) Also see N233Modified eff. 4/1/04

M30	Missing pathology report.	(Modified 8/1/04, 2/28/03) Also see N233Missing pathology report.(Modified 8/1/04, 2/28/03) Also see N236
M31	Missing radiology report.	(Modified 8/1/04, 2/28/03) Also see N240
M60	Missing Certificate of Medical Necessity.	(Modified 8/1/04, 6/30/03) Also see N227
M73	The HPSA/Physician Scarcity bonus can only be paid on the professional component of this service. Rebill as separate professional and technical components.	(Modified 8/1/04)
M74	This service does not qualify for a HPSA/Physician Scarcity bonus payment.	(Modified 8/1/04)
M124	Missing indication of whether the patient owns the equipment that requires the part or supply.	(Modified 8/1/04, 2/28/03) Also see N230
M127	Missing patient medical record for this service.	(Modified 8/1/04, 2/28/03) Also see N237
M130	Missing invoice or statement certifying the actual cost of the lens, less discounts, and/or the type of intraocular lens used.	(Modified 8/1/04, 2/28/03) Also see N231
M131	Missing physician financial relationship form.	(Modified 8/1/04, 2/28/03) Also see N239
M132	Missing pacemaker registration form.	(Modified 8/1/04, 2/28/03) Also see N235
M141	Missing physician certified plan of care.	(Modified 8/1/04, 2/28/03) Also see N238
M142	Missing American Diabetes Association Certificate of Recognition.	(Modified 8/1/04, 2/28/03) Also see N226
MA92	Missing plan information for other insurance.	(Modified 8/1/04, 2/28/03, 2/1/04) Also see N245

N3	Missing consent form.	(Modified 8/1/04, 2/28/03) Also see N228
N26	Missing itemized bill.	(Modified 8/1/04, 2/28/03) Also see N232
N29	Missing documentation/orders/notes/summary/report/invoice.	(Modified 8/1/04, 2/28/03) See N225
N40	Missing x-ray.	(Modified 2/28/03, 6/30/03, 2/1/04, 8/1/04) See N242
N121	Medicare Part B does not pay for items or services provided by this type of practitioner for beneficiaries in a Medicare Part A covered Skilled Nursing Facility (SNF) stay.	(New Code 9/9/02. Modified 8/1/04, 6/30/03)
N127	This is a misdirected claim/service for a United Mine Workers of America (UMWA) beneficiary. Please submit claims to them.	(New Code 10/31/02) Modified 8/1/04
N137	The provider acting on the Member's behalf, may file an appeal with the Payer. The provider, acting on the Member's behalf, may file a complaint with the State Insurance Regulatory Authority without first filing an appeal, if the coverage decision involves an urgent condition for which care has not been rendered. The address may be obtained from the State Insurance Regulatory Authority.	(New Code 10/31/02, Modified 2/28/03, 8/1/04)
N146	Missing screening document.	(New Code 10/31/02) Modified 8/1/04 Also see N243
N175	Missing Review Organization Approval.	(New Code 2/28/03) Modified 8/1/04 Also see N241
N178	Missing pre-operative photos or visual field results.	(New Code 2/28/03) Modified 8/1/04 Also see N244
N190	Missing contract indicator.	(New Code 2/28/03) Modified 8/1/04. Also see N229

Deactivated Remark Codes

Code	Current Narrative	Deactivation Date
M35	Missing/incomplete/invalid pre-operative photos or visual field results.	(Modified 2/28/03) Deactivated eff. 2/5/05 Refer to N178 and N244
M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.	(Modified 2/28/03) Deactivated eff. 2/5/05
MA51	Missing/incomplete/invalid CLIA certification number for laboratory services billed by physician office laboratory.	(Modified 2/28/03) Deactivate eff. 2/5/05
N38	Missing/incomplete/invalid place of service.	(Modified 2/28/03) Deactivated eff. 2/5/05 Refer to M77
N66	Missing/incomplete/invalid documentation.	(Modified 2/28/03) Deactivate eff. 2/5/05 Refer to N29 and N225

X12 N 835 Health Care Claim Adjustment Reason Codes

The Claim Adjustment Reason Code and Status Code Maintenance Committee maintains the health care claim adjustment reason codes. 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://www.wpc-edi.com/codes/Codes.asp. Select Claim Adjustment Reason Codes from the pull down menu. All reason code changes approved in June 2004 are listed here. By January 3, 2005, you must have the most current reason code set installed for production to make sure that all Medicare contractors are using the latest approved reason codes in 835, standard paper remittance advice, and coordination of benefits transactions.

The request for a reason code change may come from 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 three times a year 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.

A reason code may be retired if it is no longer applicable or a similar code exists. Retirements are effective for a specified future and succeeding versions, but contractors can also discontinue use of retired codes in prior versions. The regular code update notification will establish the deadline for Medicare contractors to retire a reason code that could be earlier than the version specified in the Washington Publishing Company (WPC) posting. The committee approved the following reason code changes in June 2004.

Reason Code Changes

Code	Current Narrative	Notes
163	Claim/Service adjusted because the attachment referenced on the claim was not received.	New as of 6/04
164	Claim/Service adjusted because the attachment referenced on the claim was not received in a timely fashion.	New as of 6/04
D16	Claim lacks prior payer payment information.	New as of 6/04 Inactive as of version 5010. Use code 16 with appropriate claim payment remark code [N4]
D17	Claim/Service has invalid non-covered days.	New as of 6/04 Inactive as of version 5010. Use code 16 with appropriate claim payment remark code [M32, M33]
D18	Claim/Service has missing diagnosis information.	New as of 6/04 Inactive as of version 5010. Use code 16 with appropriate claim payment remark code [MA63, MA65]
D19	Claim/Service lacks Physician/Operative or other supporting documentation.	New as of 6/04 Inactive as of version 5010. Use code 16 with appropriate claim payment remark code [M29, M30, M35, M66]
D20	Claim/Service missing service/product information.	New as of 6/04 Inactive as of version 5010. Use code 16 with appropriate claim payment remark code [M20, M67, M19, MA67]

New reason codes (D16-D20) were added at the request of a group of health care industry professionals who identified some situations, that happen frequently, where there is no current reason code available. For these situations, remark codes are available, but commercial payers may not use the available remark codes. The suggestion was to create a few “temporary” reason codes that would be deactivated in the next version, and could be used in lieu of remark codes. Payers currently using the appropriate combination of reason and remark codes, do not have to switch and start using the new reason codes. **Medicare will continue using the combination of reason and appropriate remark code as is currently done, and not use the new temporary reason codes.**

B. Policy: For transactions 835 (Health Care Claim Payment/Advice), 837 COB, and standard paper remittance advice, there are two code sets – reason and remark code sets – that must be used to report payment adjustments, appeal rights, and related information. 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.

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 one 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	
3466.1	Intermediaries/RHHIs/Carriers/DMERCs and VMS shall replace the modified remark codes applicable to Medicare by January 3, 2005.	X	X	X	X			X		

						Shared System Maintainers				Other
		FI	RHHI	Carrier	DMERC	FISS	MCS	VMS	CWF	
						FISS	MCS	VMS	CWF	
3466.2	Intermediaries/RHHIs/Carriers/DMERCs and VMS shall stop using any code that has been deactivated by January 3, 2005.	X	X	X	X			X		
3466.3	Intermediaries/RHHIs/Carriers/DMERCs and VMS shall add new reason and remark codes that are applicable to Medicare by January 3, 2005.	X	X	X	X			X		
3466.4	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 one 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*: January 1, 2005 **Implementation Date:** January 3, 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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