CMS Manual System

Pub. 100-04 Medicare Claims Processing

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

Transmittal 32 | **Date: NOVEMBER 21, 2003**

CHANGE REQUEST 2975

I. SUMMARY OF CHANGES: This transmittal updates the Remittance Advice Remark Code and Claim Adjustment Reason Code lists that must be used to generate a HIPAA compliant remittance advice.

NEW/REVISED MATERIAL - EFFECTIVE DATE: January 1, 2004
IMPLEMENTATION DATE: January 5, 2004

II. CHANGES IN MANUAL INSTRUCTIONS:
(R = REVISED, N = NEW, D = DELETED

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

***III. FUNDING:**

These instructions should be implemented within your current operating budget.

IV. ATTACHMENTS:

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

***Medicare contractors only**

One-Time Notification

Pub. 100-04	Transmittal: 32	Date: November 21, 2003	Change Request 2975

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

I. GENERAL INFORMATION

This one-time notification updates remark and reason codes for intermediaries, carriers and durable medical equipment regional contractors (DMERCs).

A. Background: This one-time notification updates remark and reason codes to be inserted in the electronic and paper remittance advice by intermediaries, carriers and DMERCs.

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 ASC X12 transaction 835 (Health Care Claim Payment/Advice) version 4010A1 Implementation Guide (IG). Under the Health Insurance Portability and Accountability Act (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. The CMS receives a significant number of requests for new remark codes and modifications in existing remark codes from non-Medicare entities, and these additions and modifications may not impact Medicare. Traditionally, remark code changes that impact Medicare are requested by Medicare staff in conjunction with a policy change. 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 posted on the two Web sites also have the following codes deactivated without any replacement codes: M16, MA116, and MA94. Research has revealed that these codes are still being used by Medicare contractors, and will be re-activated in the next update. These codes are not included in this document, and contractors do not need to deactivate them.

The complete list of remark codes is available at:

http://ww.cms.hhs.gov/providers/edi/hipaadoc.asp

and

http://ww.wpc-edi.com/codes/Codes.asp

The list is updated 3 times a year – in the months following X12 trimester meetings. By January 1, 2004, you must have completed entry of all applicable code text changes, new codes, and deactivation of codes that have been deactivated, for use in production, and to make sure that you are using the latest approved remark codes as included in any CMS instructions in your 835 version 4010A1 and subsequent versions, the corresponding standard

paper remittance advice transactions, and any other ANSI X12 transaction where these codes may be used (e.g., 837 COB). The following list summarizes changes made from March 1, 2003 to June 30, 2003.

Code	Current Narrative	Medicare Initiated
N202	Additional information/explanation will be sent separately.	
N203	Missing/incomplete/invalid anesthesia time/units.	
N204	Services under review for possible pre-existing condition. Send medical records for prior 12 months.	
N205	Information provided was illegible.	
N206	The supporting documentation does not match the claim.	
N207	Missing/incomplete/invalid birth weight.	
N208	Missing/incomplete/invalid DRG code.	
N209	Missing/invalid/incomplete taxpayer identification number (TIN).	
N210	You may appeal this decision.	
N211	You may not appeal this decision.	

Modified Remark Codes

Code	Current Modified Narrative	Modification Date
M13	Only one initial visit is covered per specialty per medical group.	(Modified 6/30/03)
M18	Certain services may be approved for home use. Neither a hospital nor a skilled nursing facility (SNF) is considered to be a patient's home.	(Modified 6/30/03)
M25	Payment has been adjusted because the information furnished does not substantiate the need for this level of service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this level of service, or if you notified the patient in writing in advance that we would not pay for this level of service and he/she agreed in writing to pay, ask us to review your claim within 120 days of the date of this notice. If you do not request a review, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her in excess of any deductible and coinsurance amounts. We will recover the reimbursement from you as an overpayment.	(Modified 6/30/03)

M26	Payment has been adjusted because the information furnished does not substantiate the need for this level of service. If you have collected any amount from the patient for this level of service /any amount that exceeds the limiting charge for the less extensive service, the law requires you to refund that amount to the patient within 30 days of receiving this notice. The law permits exceptions to the refund requirement in two cases: • If you did not know, and could not have reasonably been expected to know, that we would not pay for this service; or • If you notified the patient in writing before providing the service that you believed that we were likely to deny the service, and the patient signed a statement agreeing to pay for the service If you come within either exception, or if you believe the carrier was wrong in its determination that we do not pay for this service, you should request review of this determination within 30 days of the date of this notice. Your request for review should include any additional information necessary to support your position. If you request review within 30 days of receiving this notice, you may delay refunding the amount to the patient until you receive the results of the review. If the review decision is favorable to you, you do not need to make any refund. If, however, the review is unfavorable, the law specifies that you must make the refund within 15 days of receiving the unfavorable review decision. The law also permits you to request review at any time within 120 days of the date of this notice. However, a review request that is received more than 30 days after the date of this notice, does not permit you to delay making the refund. Regardless of when a review is requested, the patient will be notified that you have requested one, and will receive a copy of the determination. The patient has received a separate notice of this denial decision. The notice advises that he/she may be entitled to a refund of any amounts paid, if you should have known that we would not pay and did not tell him/her. It also instructs the patient to contact your office if he/she does not hear anything about a refund within 30 days. The requirements for refund are in 1842(l) of the Social Security Act and 42CFR411.408. The section specifies that physicians who knowingly and willfully fail to make appropriate refunds may be subject to civil monetary penalties and/or exclusion from the program. Contact this office if you have any questions about this notice.	

M60	Missing/incomplete/invalid Certificate of Medical Necessity.	(Modified 6/30/03)
M86	Service denied because payment already made for some/similar procedure within set time frame.	(Modified 6/30/03)
M117	Not covered unless submitted via electronic claim.	(Modified 6/30/03)
M129	Missing/incomplete/invalid indicator of x-ray availability for review.	(Modified 6/30/03)
M134	Performed by a facility/supplier in which the provider has a financial interest.	(Modified 6/30/03)
MA01	If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the review. However, in order to be eligible for a review, you must write to us within 120 days of the date of this notice, unless you have a good reason for being late. An institutional provider, e.g., hospital, skilled nursing facility (SNF), home health agency (HHA) or hospice may appeal only if the claim involves a reasonable and necessary denial, a SNF recertified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, or a hospice care denial because the patient was not terminally ill, and either the patient or the provider is liable under Section 1879 of the Social Security Act, and the patient chooses not to appeal. If your carrier issues telephone review decisions, a professional provider should phone the carrier's office for a telephone review if the criteria for a telephone review are met.	(Modified 6/30/03)
MA02	If you do not agree with this determination, you have the right to appeal. You must file a written request for reconsideration within 120 days of the date of this notice. Decisions made by a Quality Improvement Organization (QIO) must be appealed to that QIO within 60 days. An institutional provider, e.g., hospital, skilled nursing facility (SNF), home health agency (HHA) or a hospice may appeal only if the claim involves a reasonable and necessary denial, a SNF non-certified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, or a hospice care denial because the patient was not terminally ill, and either the patient or the provider is liable under Section1879 of the Social Security Act, and the patient chooses not to appeal.	(Modified 6/30/03)

MA03	If you do not agree with the approved amounts and $100 or more is in dispute (less deductible and coinsurance), you may ask for a hearing. You must request a hearing within 6 months of the date of this notice. To meet the $100, you may combine amounts on other claims that have been denied. This includes reopened reviews if you received a revised decision. You must appeal each claim on time. At the hearing, you may present any new evidence which could affect our decision. An institutional provider, e.g., hospital, skilled nursing facility (SNF), home health agency (HHA) or a hospice may appeal only if the claim involves a reasonable and necessary denial, a SNF noncertified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, or a hospice care denial because the patient was not terminally ill, and either the patient or the provider is liable under Section1879 of the Social Security Act, and the patient chooses not to appeal.	(Modified 6/30/03)
MA20	Skilled nursing facility (SNF) stay not covered when care is primarily related to the use of an urethral catheter for convenience or the control of incontinence.	(Modified 6/30/03)
MA24	Christian science sanitarium/skilled nursing facility (SNF) bill in the same benefit period.	(Modified 6/30/03)
MA93	Non-PIP (Periodic Interim Payment) Claim.	(Modified 6/30/03)
MA101	A skilled nursing facility (SNF) is responsible for payment of outside providers who furnish these services/supplies to residents.	(Modified 6/30/03)
MA106	PIP (Periodic Interim Payment) claim.	(Modified 6/30/03)
MA121	Missing/incomplete/invalid date the x-ray was performed.	(Modified 6/30/03)
N30	Patient ineligible for this service.	(Modified 6/30/03)
N32	Claim must be submitted by the provider who rendered the service.	(Modified 6/30/03)
N40	Missing/incomplete/invalid x-ray.	(Modified 6/30/03)
N69	PPS (Prospective Payment System) code changed by claims processing system. Insufficient visits or therapies.	(Modified 6/30/03)
N71	Your unassigned claim for a drug or biological, clinical diagnostic laboratory services or ambulance service was processed as an assigned claim. You are required by law to accept assignment for these types of claims.	(Modified 6/30/03)
N72	PPS (Prospective Payment System) code changed by medical reviewers. Not supported by clinical records.	(Modified 6/30/03)

N100	PPS (Prospect Payment System) code corrected during adjudication.	(Modified 6/30/03)
N103	Social Security records indicate that this patient was a prisoner when the service was rendered. This payer does not cover items and services furnished to an individual while they are in State or local custody under a penal authority, unless under State or local law, the individual is personally liable for the cost of his or her health care while incarcerated and the State or local government pursues such debt in the same way and with the same vigor as any other debt.	(Modified 6/30/03)
N106	Payment for services furnished to skilled nursing facility (SNF) inpatients (except for excluded services) can only be made to the SNF. You must request payment from the SNF rather than the patient for this service.	(Modified 6/30/03)
N107	Services furnished to skilled nursing facility (SNF) inpatients must be billed on the inpatient claim. They cannot be billed separately as outpatient services.	(Modified 6/30/03)
N113	Only one initial visit is covered per physician, group practice or provider.	(Modified 6/30/03)
N115	This decision was based on a local medical review policy (LMRP). An LMRP provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at http://www.cms.hhs.gov/mcd, or if you do not have web access, you may contact the contractor to request a copy of the LMRP.	(Modified 6/30/03)
N117	This service is paid only once in a patient's lifetime.	(Modified 6/30/03)
N119	This service is not paid if billed once every 28 days, and the patient has spent 5 or more consecutive days in any inpatient or skilled nursing facility (SNF) within those 28 days.	(Modified 6/30/03)
N120	Payment is subject to home health prospective payment system partial episode payment adjustment. Patient was transferred/discharged/readmitted during payment episode.	(Modified 6/30/03)
N121	No coverage for items or services provided by this type of practitioner for patients in a covered skilled nursing facility (SNF) stay.	(Modified 6/30/03)
N177	We did not send this claim to patient's other insurer. They have indicated no additional payment can be made.	(New Code 2/28/03) (Modified 6/30/03)

Deactivated Remark Codes

Code	Current Modified Narrative	Deactivation Date
M43	Payment for this service previously issued to you or another provider by another carrier/intermediary.	Deactiv. eff. 1/31/04 Refer to Reason Code 23
M48	Payment for services furnished to hospital inpatients (other than professional services of physicians) can only be made to the hospital. You must request payment from the hospital rather than the patient for this service.	Deactiv. eff. 1/31/04 Refer to M97
M63	We do not pay for more than one of these on the same day.	Deactiv. eff. 1/31/04 Refer to M86
M98	Begin to report the Universal Product Number on claims for items of this type. We will soon begin to deny payment for items of this type if billed without the correct UPN.	Deactiv. eff.1/31/04 Refer to M99
M101	Begin to report a G1-G5 modifier with this HCPCS. We will soon begin to deny payment for this service if billed without a G1-G5 modifier.	Deactiv. eff. 1/31/04 Refer to M78
M106	Information supplied does not support a break in therapy. A new capped rental period will not begin. This is the maximum approved under the fee schedule for this item or service.	Deactiv. eff. 1/31/04 Refer to MA31
M140	Service not covered until after the patient's 50th birthday, i.e., no coverage prior to the day after the 50th birthday.	Deactiv. eff. 1/31/04 Refer to M82
MA11	Payment is being issued on a conditional basis. If no-fault insurance, liability insurance, Workers' Compensation, Department of Veterans Affairs, or a group health plan for employees and dependents also covers this claim, a refund may be due us. Contact us if the patient is covered by any of these sources.	Deactiv. eff. 1/31/04 Refer to M32
MA78	The patient overpaid you. You must issue the patient a refund within 30 days for the difference between our allowed amount total and the amount paid by the patient.	Deactiv. eff. 1/31/04 Refer to MA59
MA104	Missing/incomplete/invalid date the patient was last seen or the provider identifier of the attending physician.	Deactiv. eff. 1/31/04 Refer to M128 or M57
MA124	Processed for IME only.	Deactiv. eff. 1/31/04 Refer to reason code 74
MA129	This provider was not certified for this procedure on this date of service.	Deactiv. eff. 1/31/04 Refer to MA120. and reason code B7

N18	Payment based on the Medicare allowed amount.	Deactiv. eff. 1/31/04 Refer to N14
N60	A valid NDC is required for payment of drug claims effective October 02.	Deactiv. eff. 1/31/04 Refer to M119
N73	A skilled nursing facility is responsible for payment of outside providers who furnish these services/supplies under arrangement to its residents.	Deactiv. eff. 1/31/04 Refer to MA101 or N200
N101	Additional information is needed in order to process this claim. Resubmit the claim with the identification number of the provider where this service took place. The Medicare number of the site of service provider should be preceded with the letters "HSP" and entered into item #32 on the claim form. You may bill only one site of service provider number per claim.	Deactiv. eff. 1/31/04 Refer to MA105
N164	Transportation to/from this destination is not covered.	Deactiv. eff. 1/31/04 Refer to N157
N165	Transportation in a vehicle other than an ambulance is not covered.	Deactiv. eff. 1/31/04 Refer to N158
N166	Payment denied/reduced because mileage is not covered when the patient is not in the ambulance.	Deactiv. eff. 1/31/04 Refer to N159
N168	The patient must choose an option before a payment can be made for this procedure/equipment/supply/service.	Deactiv. eff. 1/31/04 Refer to N160
N169	This drug/service/supply is covered only when the associated service is covered.	Deactiv. eff. 1/31/04 Refer to N161

X12 N 835 Health Care Claim Adjustment Reason Codes

The Health Care 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 3 times a year after each X12 trimester meeting at http://www.wpc-edi.com/codes/Codes.asp, and select Claim Adjustment Reason Codes from the pull down menu. All reason code changes approved in June 2003 are listed here. By January 1, 2004, you must have the most current reason code set installed for production to make sure that all carriers, intermediaries, and DMERCs are using the latest approved reason codes in 835 and standard paper remittance advice 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 the regular code update notification. The regular code update notification will be issued on a 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.

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 also can 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 WPC posting. The committee approved the following reason code changes in June 2003.

Reason Code Changes (as of 6/30/03)

Code	Current Narrative	Notes
155	This claim is denied because the patient refused the service/procedure.	New as of 6/03
38	Services not provided or authorized by designated (network/primary care) providers.	Modified as of 6/03
107	Claim/service denied because the related or qualifying claim/service was not previously paid or identified on this claim.	Modified as of 6/03

The following is a comprehensive list of retired reason codes. Codes that have been retired effective version 4010 must be deactivated by the implementation date of this instruction. Codes retired effective version 4010 or any previous version is bolded. Contractors must make sure that they are not inserting these codes in an 835 even though they may be generating remittance advice in a legacy format as a result of the contingency plan invoked by CMS. System limitation prohibits using codes that are retired effective version 4010 for any pre-4010 formats/versions being generated during the contingency period.

Code	Current Narrative	Notes
28	**Coverage not in effect at the time the service was provided.**	**Inactive for 004010, since 6/98. Redundant to codes 26&27.**
36	**Balance does not exceed co-payment amount.**	**Inactive for 003040**
37	**Balance does not exceed deductible.**	**Inactive for 003040**
41	**Discount agreed to in Preferred Provider contract.**	**Inactive for 003040**
46	**This (these) service(s) is (are) not covered.**	**Inactive for 004010, since 6/00. Use code 96.**
48	**This (these) procedure(s) is (are) not covered.**	**Inactive for 004010, since 6/00. Use code 96.**
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.	Inactive for 004050. Split into codes 150, 151, 152, 153 and 154.
63	**Correction to a prior claim.**	**Inactive for 003040**

64	**Denial reversed per medical review.**	**Inactive for 003040**
65	**Procedure code was incorrect. This payment reflects the correct code.**	**Inactive for 003040**
67	**Lifetime reserve days. (Handled in QTY, QTY01=LA)**	**Inactive for 003040**
68	**DRG weight. (Handled in CLP12)**	**Inactive for 003040**
71	**Primary payer amount.**	**Deleted as of 6/00. Use code 23.**
72	**Coinsurance day. (Handled in QTY, QTY01=CD)**	**Inactive for 003040**
73	**Administrative days.**	**Inactive for 003050**
77	**Covered days. (Handled in QTY, QTY01=CA)**	**Inactive for 003040**
79	**Cost Report days. (Handled in MIA15)**	**Inactive for 003050**
80	**Outlier days. (Handled in QTY, QTY01=OU)**	**Inactive for 003050**
81	**Discharges.**	**Inactive for 003040**
82	**PIP days.**	**Inactive for 003040**
83	**Total visits.**	**Inactive for 003040**
84	**Capital Adjustment. (Handled in MIA)**	**Inactive for 003050**
86	**Statutory Adjustment.**	**Inactive for 004010, since 6/98. Duplicative of code 45.**
88	Adjustment amount represents collection against receivable created in prior overpayment.	Inactive for 004050.
92	**Claim paid in full.**	**Inactive for 003040**
93	**No claim level adjustments.**	**Inactive for 004010, since 2/99. In 004010, CAS at the claim level is optional.**
98	**The hospital must file the Medicare claim for this inpatient non-physician service.**	**Inactive for 003040**
99	**Medicare Secondary Payer Adjustment Amount.**	**Inactive for 003040**
120	Patient is covered by a managed care plan.	Inactive for 004030
123	Payer refund due to overpayment.	Inactive for 004030, since 6/99. Refer to implementation guide for proper handling of reversals.

124	Payer refund amount - not our patient.	Inactive for 004030, since 6/99. Refer to implementation guide for proper handling of reversals.
A3	**Medicare Secondary Payer liability met.**	**Inactive for 004010, since 6/98.**
B2	**Covered visits.**	**Inactive for 003040**
B3	**Covered charges.**	**Inactive for 003040**
B19	**Claim/service adjusted because of the finding of a Review Organization.**	**Inactive for 003070**
B21	**The charges were reduced because the service/care was partially furnished by another physician.**	**Inactive for 003040**
D1	**Claim/service denied. Level of subluxation is missing or inadequate.**	**Inactive for 004010, since 2/99. Use code 16 and remark codes if necessary.**
D2	**Claim lacks the name, strength, or dosage of the drug furnished.**	**Inactive for 004010, since 2/99. Use code 16 and remark codes if necessary.**
D3	**Claim/service denied because information to indicate if the patient owns the equipment that requires the part or supply was missing.**	**Inactive for 004010, since 2/99. Use code 16 and remark codes if necessary.**
D4	**Claim/service does not indicate the period of time for which this will be needed.**	**Inactive for 004010, since 2/99. Use code 16 and remark codes if necessary.**
D5	**Claim/service denied. Claim lacks individual lab codes included in the test.**	**Inactive for 004010, since 2/99. Use code 16 and remark codes if necessary.**
D6	**Claim/service denied. Claim did not include patient's medical record for the service.**	**Inactive for 004010, since 2/99. Use code 16 and remark codes if necessary.**
D7	**Claim/service denied. Claim lacks date of patient's most recent physician visit.**	**Inactive for 004010, since 2/99. Use code 16 and remark codes if necessary.**
D8	**Claim/service denied. Claim lacks indicator that `x-ray is available for review.'**	**Inactive for 004010, since 2/99. Use code 16 and remark codes if necessary.**

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.**	**Inactive for 004010, since 2/99. Use code 16 and remark codes if necessary.**
D10	**Claim/service denied. Completed physician financial relationship form not on file.**	**Inactive for 003070, since 8/97. Use code 17.**
D11	**Claim lacks completed pacemaker registration form.**	**Inactive for 003070, since 8/97. Use code 17.**
D12	**Claim/service denied. Claim does not identify who performed the purchased diagnostic test or the amount you were charged for the test.**	**Inactive for 003070, since 8/97. Use code 17.**
D13	**Claim/service denied. Performed by a facility/supplier in which the ordering/referring physician has a financial interest.**	**Inactive for 003070, since 8/97. Use code 17.**
D14	**Claim lacks indication that plan of treatment is on file.**	**Inactive for 003070, since 8/97. Use code 17.**
D15	**Claim lacks indication that service was supervised or evaluated by a physician.**	**Inactive for 003070, since 8/97. Use code 17.**

B. Policy:

Contractors must implement the necessary changes by January 1, 2004.

C. Provider Education: Effected providers must be notified in advance about the changes in the Remittance Advice Remark Codes and Claim Adjustment Reason Codes that are going to be used in remittance advice (electronic and paper), and any other transaction that will be impacted by these changes.

II. BUSINESS REQUIREMENTS

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

Requirement #	Requirements	Responsibility
2975.1	Intermediaries/carriers/DMERCs shall replace retired and modified remark and reason codes that are applicable to Medicare by January 1, 2004.	Intermediaries/ carriers/ DMERCs
2975.2	Intermediaries/carriers/DMERCs shall add new remark and reason codes that are applicable to Medicare by January 1, 2004.	Intermediaries/ carriers/ DMERCs
2975.3	Intermediaries/carriers/DMERCs shall furnish provider education about changes in remittance advice codes. Intermediaries/carriers/DMERCs shall inform affected provider communities by posting relevant portions of this instruction on their Web sites within 2-3 weeks of the issuance date on this instruction. In addition, this same information shall be published in your next regularly scheduled bulletin. If you have a listserv that targets the affected provider communities, you shall use it to notify	Intermediaries/ carriers/ DMERCs

	subscribers that information about the Remittance Advice Remark and Reason Code Update is available on your Web site.	

III. SUPPORTING INFORMATION & 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, 2004 **Implementation Date: January 5, 2004** **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**	**These instructions should be implemented within your current operating budget**