Program Memorandum Intermediaries/Carriers

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

Transmittal AB-02-142 | Date: OCTOBER 18, 2002

CHANGE REQUEST 2395

SUBJECT: Remittance Advice Coding Update

This Program Memorandum (PM) updates remark and reason codes for intermediaries, carriers and Durable Medical Equipment Regional Contractors (DMERCs).

X12N 835 Health Care Remittance Advice Remark Codes

CMS is the national maintainer of remittance advice remark codes used by both Medicare and non-Medicare entities. Under the Health Insurance Portability and Accountability Act (HIPAA), all payers have to use reason and remark codes approved by X-12 recognized maintainers of those code sets instead of proprietary codes to explain any adjustment in the payment. As a result, a significant number of remark code changes in the future will be requested by non-Medicare entities, and 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 in the form of a PM or manual instruction implementing the policy change, in addition to the regular code update PM.

The list of remark codes is available at http://www.cms.hhs.gov/medicare/edi/hipaadoc.asp and http://www.wpc-edi.com/hipaa/, and the list is updated each March, July, and November. By January 1, 2003, you must have completed entry of all applicable code changes and new codes for use in production, and continue downloading from one of the above mentioned web sites every 4 months to make sure that all Medicare carriers, intermediaries, and DMERCs are using the latest approved remark codes as included in any CMS instructions in their 835 version 4010 and subsequent versions, and the corresponding standard paper remittance advice transactions. Contractor and shared system changes must be made, as necessary, as part of a routine release to reflect changes such as retirement of previously used codes or newly created codes that may impact Medicare.

The following list summarizes changes made through June 30, 2002.

New Remark Codes

Code	Current Narrative
N113	You or someone in your group practice has already submitted a claim for an initial visit for this beneficiary. Medicare pays only once per beneficiary per physician, group practice, or provider for an initial visit.
N114	During the transition to the Ambulance Fee Schedule, payment is based on the lesser of a blended amount calculated using a percentage of the reasonable charge/cost and fee schedule amounts, or the submitted charge for the service. You will be notified yearly what the percentages for the blended payment calculation will be.

Code	Current Narrative
N115	This decision is based on a local medical review policy (LMRP). An LMRP provides a guide to assist in determining whether a particular item or service is reasonable and necessary. A copy of this policy is available at www.LMRP.net
N116	This payment is being made conditionally because the service was provided in the home, and it is possible that the patient is under a home health episode of care. When a patient is treated under a home health episode of care, consolidated billing requires that certain therapy services and supplies, such as this, be included in the home health agency's (HHA's) payment. This payment will need to be recouped from you if we establish that the patient is concurrently receiving treatment under an HHA episode of care.

Modified Remark Codes

M25 Payment has been (denied for the/made only for a less extensive) service because the information furnished does not substantiate the need for the (more extensive) 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 (more extensive) service, or if you notified the patient in writing in advance that we would not pay for this (more extensive) service and he/she agreed in writing to pay, ask us to review your claim either within 6 months of the date of this notice, if this notice is dated September 30, 2002, or earlier, or within 120 days of the date of this notice, if this notice is dated October 1, 2002, or later. 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 (for the/in excess of any deductible and coinsurance amounts applicable to the less extensive) service. We will recover the reimbursement from you as an overpayment.

M26 Payment has been (denied for the/made only for a less extensive) service because the information furnished does not substantiate the need for the (more extensive) service. If you have collected (any amount from the patient/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. 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.

Code	Current Narrative
	The law also permits you to request review at any time within 6 months of the date of this notice, if this notice is dated September 30, 2002, or earlier or within 120 days of the date of this notice, if this notice is dated October 1, 2002, or later. 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 42 CFR 411.408. 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.
	Please contact this office if you have any questions about this notice.
M27	The patient has been relieved of liability of payment of these items and services under the limitation of liability provision of the law. You, the provider, are ultimately liable for the patient's waived charges, including any charges for coinsurance, since the items or services were not reasonable and necessary or constituted custodial care, and you knew or could reasonably have been expected to know, that they were not covered.
	You may appeal this determination provided that the patient does not exercise his/her appeal rights. If the beneficiary appeals the initial determination, you are automatically made a party to the appeals determination. If, however, the patient or his/her representative has stated in writing that he/she does not intend to request a reconsideration, or the patient's liability was entirely waived in the initial determination, you may initiate an appeal.
	You may ask for a reconsideration for hospital insurance (or a review for medical insurance) regarding both the coverage determination and the issue of whether you exercised due care. The request for reconsideration must be filed within 60 days of the date of this notice, if this notice is dated September 30, 2002, or earlier or within 120 days of the date of this notice, if this notice is dated October 1, 2002, or later (or, for a medical insurance review, within 6 months of the date of this notice, if this notice is dated September 30, 2002, or earlier or within 120 days of the date of this notice, if this notice is dated October 1, 2002, or later). You may make the request through any Social Security office or through this office.
MA01	(Initial Part B determination, Medicare carrier or intermediary)--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 6 months of the date of this notice, if this notice is dated September 30, 2002, or earlier or within 120 days of the date of this notice, if this notice is dated October 1, 2002, or later, unless you have a good reason for being late.
	(**NOTE:** An Intermediary must add: An institutional provider, e.g., hospital, SNF, HHA or hospice may appeal only if the claim involves a medical necessity denial, a SNF recertified bed denial, or a home health denial because the patient was not

Code	Current Narrative
	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 §1879 of the Social Security Act, and the patient chooses not to appeal.) (**NOTE**: Carriers who issue telephone review decisions should add: If you meet the criteria for a telephone review, you should phone this office if you wish to request a telephone review.)
MA02	(Initial Medicare Part A determination)--If you do not agree with this determination, you have the right to appeal. You must file a written request for a reconsideration within 60 days of the date of this notice, if this notice is dated September 30, 2002, or earlier or within 120 days of the date of this notice, if this notice is dated October 1, 2002, or later. Decisions made by a QIO must be appealed to that QIO within 60 days. (An institutional provider, e.g., hospital, SNF, HHA or a hospice may appeal only if the claim involves a medical necessity 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 §1879 of the Social Security Act, and the patient chooses not to appeal.)
N103	Social Security records indicate that this beneficiary was a prisoner when the service was rendered. Medicare does not cover items and services furnished to beneficiaries while they are in State or local custody under a penal authority, unless under State or local law, the beneficiary 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.

Additionally, the following codes were modified before February 28, 2002, but were not included in Transmittal AB-02-067 (CR 1959).

Code	Current Narrative
MA49	Missing/Incomplete/invalid six-digit provider number of home health agency or hospice for physician(s) performing care plan oversight services.
MA50	Missing/Incomplete/invalid Investigational Device Exemption number for FDA-approved clinical trial services.
MA51	Missing/Incomplete/invalid CLIA certification number for laboratory services billed by physician office laboratory.
MA82	Did not complete or enter the correct physician/physician assistant/nurse practitioner/clinical nurse specialist/supplier's billing number/NPI and/or billing name, address, city, state, zip code, and phone number.
MA112	Our records indicate that the performing physician/physician assistant/clinical nurse specialist/certified registered nurse anesthetist/anesthesia assistant/supplier/nurse practitioner is a member of a group practice; however, you did not complete or enter accurately the group's name, address, zip code and their carrier assigned individual and group PINs. (Substitute "NPI" for "PIN" when effective.)

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 three times a year after each X12 trimester meeting at http://www.wpc-edi.com/hipaa/. By January 1, 2003, you must have the most current reason code set installed for production, and continue downloading from the above mentioned web site every 4 months to make sure that all Medicare carriers, intermediaries, and DMERCs are using the latest approved reason codes in 835 and standard paper remittance advice transactions.

In most cases, reason code additions, modifications and retirements are requested by non-Medicare entities, Medicare may occasionally request changes. If the request comes from Medicare, it may be included in a Medicare instruction in addition to the regular code update program memorandum. Code changes requested by entities other than Medicare would not be routinely included in a Medicare instruction as part of a policy change, but modification or retirement of an existing code could impact Medicare. A PM will be issued on a periodic basis to provide a summary of changes in the reason and remark codes introduced since the last update PM, and will establish the deadline for Medicare contractors to implement the reason and remark code changes applicable to Medicare 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. Contractors and shared system maintainers must modify their maps or programming as necessary by the date the specified electronic version or a higher numbered version is implemented or earlier if the replacing code is available for the earlier version(s), if a retired code is being used.

The committee approved the following reason code changes in June 2002:

New Reason Codes

Code	Current Narrative
145	Premium payment withholding
146	Payment denied because the diagnosis was invalid for the date(s) of service reported.
147	Provide contracted/negotiated rate expired or not in file
148	Claim/service rejected at this time because information from another provider was not provided or was insufficient/incomplete.

Modified Reason Codes

Code	Current Narrative
6	The procedure/revenue code is inconsistent with the patient’s age.
7	The procedure/revenue code is inconsistent with the patient’s gender.
8	The procedure/revenue code is inconsistent with the provider type/specialty (taxonomy).
108	Payment adjusted because rent/purchase guidelines were not met.

Implementation of Reason and Remark Codes

As instructed before, shared system maintainers must provide a crosswalk between the reason and remark codes to the shared system internal codes so that a carrier or DMERC or intermediary can easily locate and update each internal code that may be impacted by a remittance advice reason/remark code change to eliminate the need for lengthy and error prone manual carrier/DMERC/intermediary searches to identify each affected internal code.

The effective date of programming for use of new or modified reason/remark codes applicable to Medicare is the earlier of the date specified in the contractor manual transmittal or PM requiring implementation of a policy change that led to the issuance of the new/modified code, or the date specified in the periodic PM announcing issuance of the code changes. Contractors must notify providers of the new and/or modified codes and their meanings in a provider bulletin or other instructional release prior to issuance of remittance advice transactions that include these changes.

Medicare contractors must use appropriate remark codes in conjunction with the appropriate reason code(s) when applicable, and must make sure that they are using the currently valid reason and remark codes.

The *effective date* for this Program Memorandum (PM) is January 1, 2003.

The *implementation date* for this PM is January 1, 2003.

These instructions should be implemented within your current operating budget.

This PM may be discarded after January 1, 2004.

If you have any questions, contact Sumita Sen at 410-786-5755 or ssen@cms.hhs.gov**.**