CMS Manual System

Pub. 100-04 Medicare Claims Processing

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

Transmittal 154 | **Date: APRIL 30, 2004**

CHANGE REQUEST 3227

I. SUMMARY OF CHANGES: This contains information about reason and remark code updates from November 2003 through February 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.

CLARIFICATION – EFFECTIVE DATE: July 1, 2004
IMPLEMENTATION DATE: July 6, 2004

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:
(R = REVISED, N = NEW, D = DELETED)

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

***III. FUNDING:**

These instructions shall be implemented within your current operating budget.

IV. ATTACHMENTS:

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

***Medicare contractors only**

Attachment – Recurring Update Notification

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

I. GENERAL INFORMATION

A. Background: Per the Health Insurance Portability and Accountability Act (HIPAA) of 1996, health plans must be able to conduct standard electronic transactions for transactions mentioned in the regulation.

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. 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 complete list of remark codes is available at:

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

The list is updated 3 times a year. By July 6, 2004, 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 November 1, 2003 to February 29, 2004.

New Code	Current Narrative	Medicare Initiated
N213	Missing/incomplete/invalid facility/discrete unit DRG/DRG exempt status information.	N

N214	Missing/incomplete/invalid history of history of the related initial surgical procedure(s).	N
N215	A payer providing supplemental or secondary coverage shall not require a claims determination for this service from a primary payer as a condition of making its own claims determination.	Y
N216	Patient is not enrolled in this portion of our benefit package.	Y

Modified Remark Codes

Code	Current Modified Narrative	Modification Date
M119	Missing/incomplete/invalid/deactivated/withdrawn National Drug Code.	Modified eff. 4/1/04
N115	This decision is based on a Local Medical Review Policy (LMRP) or Local Coverage Determination (LCD). An LMRP/LCD 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/LCD.	Modified eff. 4/1/04

The following codes were modified in the last update, but were not included in the last code update CR 3122.

M51	Missing/incomplete/invalid procedure code(s) and/or dates.	Modified eff. 2/1/04
M69	Paid at the regular rate as you did not submit documentation to justify the modified procedure code.	Modified eff. 2/1/04
MA53	Missing/incomplete/invalid Competitive Bidding Demonstration Project identification.	Modified eff. 2/1/04
MA92	Missing/incomplete/invalid plan information for other insurance.	Modified eff. 2/1/04

Deactivated Remark Codes

None

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. Select Claim Adjustment Reason Codes from the pull down menu. All reason code changes approved in February 2004 are listed here. By July 6, 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, 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 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 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 February 2004. They may not be posted to the WPC Web site at the time this CR is published, but will be included in the next update.

Reason Code Changes

Code	**Current Narrative**	**Notes**
161	Provider performance bonus.	New as of 2/04
162	State –mandated Requirement for Property and Casualty, see Claim Payment Remarks code for specific explanation.	New as of 2/04

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 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.

II. BUSINESS REQUIREMENTS

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

Requirement #	Requirements	Responsibility
3227.1	Intermediaries/Carriers/DMERCs and VMS shall replace the modified remark codes applicable to Medicare by July 6, 2004.	Intermediaries/ Carriers/ DMERCs/VMS
3227.2	Intermediaries/Carriers/DMERCs, and VMS shall add new remark and reason codes applicable to Medicare by July 6, 2004.	Intermediaries/ Carriers/ DMERCs/VMS
3227.3	Intermediaries/Carriers/DMERCs shall furnish provider education about changes in remittance advice 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.	Intermediaries/ Carriers/ DMERCs

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: July 1, 2004 **Implementation Date:** July 6, 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 shall be implemented within your current operating budget.**