CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1770	**Date: January 6, 2017**
	Change Request 9681

Transmittal 1733, dated October 27, 2016, is being rescinded and replaced by Transmittal 1770, dated, January 6, 2017, to modify the example Types of Bills (TOBs) listing included in the last paragraph of the Policy section and in requirement 9681.3 to remove TOB 82x. All other information remains the same.

SUBJECT: Modifications to the National Coordination of Benefits Agreement (COBA) Crossover Process

I. SUMMARY OF CHANGES: Through this instruction the Centers for Medicare & Medicaid Services (CMS) modifies the Part A shared system to ensure that all 837 institutional Coordination of Benefits (COB) claims will contain a Claim Adjustment Reason Code and Remittance Advice Remark Code combination as required and as reported on the 835 Electronic Remittance Advice that has been sent to the provider. Additionally, CMS modifies the Part A shared system to ensure that hospital day counts may not be entered duplicatively on incoming claims submissions to Medicare and that Present on Admission (POA) indicators are only permitted on incoming inpatient hospital-oriented claims.

EFFECTIVE DATE: April 1, 2017
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 3, 2017

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:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. 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.

IV. ATTACHMENTS:
One Time Notification

Attachment - One-Time Notification

Pub. 100-20	Transmittal: 1770	Date: January 6, 2017	Change Request: 9681

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I. GENERAL INFORMATION

A. Background: This instruction addresses three (3) separate issues associated with the COBA claims crossover process: Making sure that the Part A shared system will create 837 institutional claims and 835 Electronic Remittance Advices (ERAs) that contain a Claim Adjustment Segment (CAS) Group Code, a Claim Adjustment Reason Code (CARC), and a non-alert Remittance Advice Reason Code (RARC) when required; creating an edit within the Part A shared system to prevent the duplicate entry of hospital day counts expressed as value codes (e.g., value code 80, 81, 82); and, creating edits within the Part A shared system to prevent reporting of Present on Admission (POA) indicators on outpatient Coordination of Benefits (COB) facility claims.

Currently, the Washington Publishing Company publishes and maintains a listing of all valid, as well as deactivated, CARCs and RARCs. In addition, the Council for Affordable Quality Healthcare Committee for Operating Rules for Information Exchange (CAQH CORE) dictates which Group Code and CARC and RARC combinations must be used by all covered entities in the healthcare industry under four (4) CAQH CORE business scenarios. Medicare routinely reports Group Codes, CARCs, and RARCs on Health Insurance Portability and Accountability Act (HIPAA) Accredited Standards Institute (ASC) 835 Electronic Remittance Advice (ERA) transactions in accordance with HIPAA and Affordable Care Act (ACA) requirements. Medicare also includes Group Codes and CARCs and RARCs within HIPAA ASC 837-N claims transactions, including 837 Coordination of Benefits (COB) claims transactions. However, within 837 claims transactions, RARCs are referred to as "Claim Payment Reason Codes" and appear within the 2320 Medicare Inpatient Adjudication Information (MIA) and Medicare Outpatient Adjudication Information (MOA) segments.

As a result of systems issues, Medicare Administrative Contractors (MACs) are not always including a valid and relevant RARC (or Claim Payment Reason Code) associated to a CARC when they deny Medicare claims. Though not the only example, this scenario seems to occur frequently when a claim service line is editing to deny with CARC code 16-- "Claim lacks information or has submission/billing error(s) which is needed for adjudication..... At least one Remark Code must be provided." Such actions are not in compliance with HIPAA and CAQH CORE requirements and must be remedied.

The Part A shared system is producing instances of duplicated hospital day counts on outbound 837 institutional COB/crossover claims. CMS attempts to address this duplication issue through this instruction.

Lastly, at present there is no editing with the Part A shared system to prevent the entry of a POA indicator on incoming outpatient facility claims. CMS remedies this concern through this instruction.

B. Policy: The Part B Medicare Administrative Contractors (MACs) shall ensure that they map a valid and relevant non-alert RARC, as prescribed by the CAQH CORE combination listing, in association with CARC 16 to the 837 COB flat file fields that correspond to the 2320 MOA03 element and within outbound 835 ERAs. (Note: For Part B 835 ERAs, the non-Alert RARC could be at the service line loop in the Loop 2110 LQ Segment as well as at the claim level in the Loop 2100 MOA segment.) To address the CARC and RARC combination requirement (including concerns about CARC 16 and an associated non-alert RARC) more globally, the Part A shared system shall create a new claim level non-alert RARC field within claim page 11 of the Fiscal Intermediary Shared System (FISS) claims screen. Additionally, the Part A shared system shall modify its outbound 837 COB and 835 ERA processes to make use of the new claim level non-alert RARC value. The Part A shared system shall continue to report informational alert RARCs in the 2320 MIA or MOA segment, as appropriate. The Part A shared system shall also continue to reflect the non-alert RARC code associated to CARC 96, first, within outbound 837 COB claims.

To eliminate duplication of hospital day counts (e.g., value codes 80, 81, 82, or 83) within the 2300 Health Information (HI) segment of outbound 837 institutional inpatient COB claims, the Part A shared system shall create an edit that will prevent providers from submitting hospital day counts associated to covered days, non-covered days, co-insurance days, and Life-Time Reserve (LTR) days more than once (duplicatively) on incoming Medicare claims, regardless of format. MACs (Part A, HHH) shall Return-to-Provider (RTP) any claims on which they encounter the newly developed duplication edit.

The Part A shared system shall develop an edit that will activate when incoming outpatient-oriented claims (i.e., types of bills (TOB) other than 11x, 18x, 21x, and 41x) contain a reported POA indicator. MACs (Part A, HHH) shall RTP any claims on which they encounter the newly developed edit.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9681.1	The Part B MACs shall make certain that they map a valid and relevant non-alert RARC, as prescribed by the CAQH CORE combination listing, in association with CARC 16 to the 837 COB flat file fields that correspond to the 2320 MOA03 element and within outbound 835 ERAs. (Note: For Part B 835 ERAs, the non-Alert RARC could be at the service line loop in the Loop 2110 LQ Segment as well as at the claim level in the Loop 2100 MOA segment.)		X							
9681.1.1	To address the CARC and RARC combination requirement (including concerns about CARC 16 and an associated non-alert RARC) more globally, the Part A shared system shall create a new claim level non-alert RARC field within claim page 11 of the FISS claims screen.					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9681.1.2	Additionally, the Part A shared system shall modify its outbound 837 COB and 835 ERA processes to make use of the new claim level non-alert RARC value.					X				
9681.1.3	The Part A shared system shall continue to reflect the non-alert RARC code associated to CARC 96 first within all outbound 837 institutional COB claims.					X				
9681.1.4	The Part A shared system shall continue to report informational alert RARCs in the 2320 MIA or MOA segment, as appropriate.					X				
9681.2	To eliminate duplication of hospital day counts (e.g., value codes 80, 81, 82, or 83) within the 2300 HI segment of outbound 837 institutional inpatient COB claims, the Part A shared system shall create an edit that will prevent providers from submitting hospital day counts associated to covered days, non-covered days, co-insurance days, and LTR days more than once (duplicatively) on incoming Medicare claims, regardless of format.					X				
9681.2.1	MACs (Part A, HHH) shall RTP any claims on which they encounter the newly-developed duplicate day count edit.	X		X						
9681.3	The Part A shared system shall develop an edit that will activate when incoming outpatient-oriented claims (i.e., TOB other than 11x, 18x, 21x, and 41x) contain a reported POA indicator.					X				
9681.3.1	MACs (Part A, HHH) shall RTP any claims on which they encounter the newly developed edit.	X		X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility		
		A/B MAC	DME	CED

		A	B	H H H	M A C	I
9681.4	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/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 sites and include information about it in a listserv message within 5 business days after receipt of the notification from CMS announcing the availability of the article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X		

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Brian Pabst, 410-786-2487 or brian.pabst@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
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ATTACHMENTS: 0