CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1585	**Date: December 16, 2015**
	Change Request 9054

Transmittal 1498, dated May 8, 2015, is being rescinded and replaced by Transmittal 1585 to change the effective and implementation dates for all FISS requirements from January 1, 2016, and January 4, 2016, to July 1, 2016, and July 5, 2016. All other information remains the same.

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

I. SUMMARY OF CHANGES: Through this change request, the Centers for Medicare & Medicaid Services (CMS) makes certain that the shared systems maintainers will always report a relevant remark code within the 2320 Medicare Inpatient Adjudication Information (MIA) and Medicare Outpatient Adjudication Information (MOA) segment of outbound 837 Coordination of Benefits (COB) claims. This instruction also addresses a related issue with 835 Electronic Remittance Advices created for inpatient hospital claims. The instruction also ensures that payment remark codes tied to a given Claim Adjustment Reason Code (CARC) will be mapped out on 837 professional crossover claims, as the number of 2320 MOA iterations permits. Lastly, this instruction makes sure that logic used in the Part B shared system to determine full payment on claims that also contain partially denied service lines is aligned with the logic used by the Common Working File (CWF) system.

EFFECTIVE DATE: October 1, 2015; *July 1*, 2016 - (For all FISS requirements)
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 5, 2015; *July 5*, 2016 - (For all FISS requirements)

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	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: 1585	Date: December 16, 2015	Change Request: 9054

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I. GENERAL INFORMATION

A. Background: The Washington Publishing Company publishes and maintains a listing of all valid, as well as deactivated, Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs). Additionally, the Council for Affordable Quality Healthcare Committee for Operating Rules for Information Exchange (CAQH CORE) dictates which CARC and RARC combinations must be used by all covered entities in the healthcare industry. Providers routinely report CARCs and RARCs on Health Insurance Portability and Accountability Act (HIPAA) Accredited Standards Committee (ASC) 835 Electronic Remittance Advice (ERA) transactions in accordance with HIPAA requirements. CARCs also appear within HIPAA ASC 837 claims transactions, including 837 Coordination of Benefits (COB) claims transactions. Additionally, Medicare reports RARCs in the 837 COB claims transactions but under the label "Claim Payment Reason Code" within 2320 MIA (Medicare Inpatient Adjudication Information) and MOA (Medicare Outpatient Adjudication Information) segments.

Currently, as a result of systems issues, Medicare Administrative Contractors (MACs) are not including a valid and relevant Claim Payment Reason Code in the 2320 MIA or MOA segments when they deny claims using CARC 96--"Non-covered charge(s)." Such actions are not in compliance with HIPAA and CAQH CORE requirements and must be remedied.

The Centers for Medicare & Medicaid Services (CMS) has determined that the Part B shared system is not including RARCs associated with CARC 237 in the 2320 MOA segment. CMS addresses this issue through this instruction.

Lastly, the Common Working File (CWF) system currently maintains logic that allows for selection of Part B crossover claims that contain both fully reimbursable (100 percent paid) and denied service lines if beneficiary liability exists on any of the denied lines. CMS has determined that the Part B system is not applying its “100 percent reimbursable claim with denied service lines” logic correctly prior to sending its claims to CWF. CMS remedies this issue through this instruction.

B. Policy: The Part A and Durable Medical Equipment Medicare Administrative Contractor (DME MAC) shared systems shall map a valid and relevant RARC, as prescribed by the CAQH CORE combination listing, in association with CARC 96 in the fields of the 837 COB flat file that correspond to the 2320 MIA05 or 2320 MOA03 element, as appropriate. When claims are denied with CARC 96, the affected shared systems shall map the first non-alert RARC to the 2320 MOA segment of their outpatient facility or DME MAC crossover claims, as described in the business requirements below. For all crossover claims created, the affected shared systems shall continue to report informational alert RARCs in the 2320 MIA or MOA segment, as further described below. The Part A system shall follow the requirements provided below in reflecting the first non-alert RARC associated with inpatient hospital claims denied with CARC 96 on outbound 837 institutional

crossover claims. Additionally, for inpatient claims, the Part A shared system shall correct the current lack of RARC reporting in association with CARC 96 on the 835 ERA.

For all 837 professional crossover claims created, the Part B shared system shall map the applicable RARC(s) used with CARC 237 to the 2320 MOA04 through MOA07 elements when possible. CMS recognizes there are only five (5) available elements within the 2320 MOA in which remark codes may be mapped. Therefore, the Part B shared system shall complete the 2320 MOA payment remark code elements in the following order of precedence, always mapping "non-alert" RARCs prior to “alert” RARCs:

- Map all header-level RARCs first;
- Then, map any detail-level RARCs associated with CARC 96 before any other detail-level RARCs; and
- Lastly, map all detail-level RARCs associated with CARC 237 before all other any other detail-level RARCs.

To address CWF’s inadvertent triggering of its “AF” (“Fully reimbursable claim containing denied lines with no beneficiary liability excluded”) crossover disposition logic, the Part B shared system shall now modify its fully reimbursable (100 percent paid) claim lines logic for 837 professional crossover claims as specified in the business requirements below. After making the determination that various claim lines are fully reimbursable, the Part B shared system shall follow its current logic for setting the “HUBC Detail Liability Indicator" on those denied claim service detail lines on which the beneficiary has payment responsibility (Group Code PR) before sending the claim to CWF.

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	
9054.1	The Part A and Durable Medical Equipment Medicare Administrative Contractor (DME MAC) shared systems shall map a valid and relevant RARC, as prescribed by the CAQH CORE combination listing, in association with CARC 96 in the fields of the 837 COB flat file that correspond to the 2320 MIA05 or 2320 MOA03 claim element, as appropriate.					X		X		
9054.1.1	When claims are denied with CARC 96, the affected shared systems shall map the first non-alert RARC (e.g., a RARC other than MA01, MA18, or N89) to the 2320 MOA03 element of their outpatient facility or DME MAC crossover claims.					X		X		
9054.1.2	For all crossover claims created, the affected shared systems shall continue to report other informational					X		X		

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	alert RARCs (e.g., MA01, MA18, or N89) in the 2320 MIA20 through MIA23 elements and in the 2320 MOA04 through MOA07 elements, as applicable.									
9054.2	For inpatient hospital claims denied using CARC 96, the Part A shared system shall map the first non-alert header-level RARC (e.g., a RARC other than MA01, MA18, or N89) to the 2320 MIA05 element within the outbound 837 crossover claims.					X				
9054.2.1	Additionally, for inpatient claims, the Part A shared system shall correct the current lack of RARC reporting in association with CARC 96 on the 835 ERA.					X				
9054.3	For all 837 professional crossover claims created, the Part B shared system shall map the applicable RARC(s) [payment remark codes] used with CARC 237 (that is, RARCs N699, N700, and N701) to the 2320 MOA04 through MOA07 elements when space allows.						X			
9054.3.1	CMS recognizes there are only five (5) available iterations of the 2320 MOA in which remark codes may be mapped. Therefore, the Part B shared system shall complete mapping of the 2320 MOA payment remark code elements in the following order of precedence, always mapping "non alert" RARCs prior to alert RARCs: • Map all header-level RARCs first; • Then map any detail-level RARCs associated with CARC 96 before any other detail-level RARCs; and • Lastly, map all detail-level RARCs associated with CARC 237 before all other detail-level RARCs.						X			
9054.4	To address CWF's inadvertent triggering of its "AF" crossover disposition logic, the Part B shared system shall now make its determination that claim lines are fully reimbursable (100 percent paid) by verifying that						X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	there are no Part B deductible, co-insurance, or any other "patient responsibility" amounts contained on the claim. (NOTE: This represents a change from previous logic, where the Part B shared system compared the claim's allowed and paid amounts to determine if the claim lines were fully reimbursable.)									
9054.4.1	After making the determination that various claim lines are fully reimbursable, the Part B shared system shall follow its pre-existing logic for setting the "HUBC Detail Liability Indicator" on those denied claim service detail lines on which the beneficiary has payment responsibility (Group Code PR) before sending the claim to CWF.						X			

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

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

"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