DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

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Re-released products from the Medicare Learning Network® (MLN)

- "Internet-based Provider Enrollment, Chain and Ownership System (PECOS) Contact Information," Fact Sheet, ICN 903766, Downloadable only.

MLN Matters® Number: MM8182

Related Change Request (CR) #: CR 8182

Related CR Release Date: August 30, 2013

Effective Date: October 1, 2013

Related CR Transmittal #: R1291OTN

Implementation Date: October 7, 2013, except January 6, 2014 for claims processed by DME MACs

Standardizing the Standard - Operating Rules for Code Usage in Remittance Advice

Note: This article was revised on September 16, 2013, to add a reference to MM8365 (http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8365.pdf) for business scenarios, descriptions and updates related to Rule 3 of the Operating Rule Set – CORE-defined Claim Adjustment and Denials to become effective January 1, 2014. All other information remains the same.

Provider Types Affected

This MLN Matters® Article is intended for physicians, other providers, and suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries (FIs), Regional Home Health Intermediaries, (RHHIs), Medicare Administrative Contractors (A/B MACs), or Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for services to Medicare beneficiaries.

What You Need To Know

CR 8182, from which this article is taken, instructs your Medicare contractor to implement the Phase III Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) Electronic Funds Transfer (EFT) & Electronic Remittance Advice (ERA) Operating Rule Set for code usage in Electronic Funds Transfer (EFT) & Electronic Remittance Advice (ERA) by January 1, 2014.

Background

The Health Insurance Portability and Accountability Act (HIPAA) amended Title XI of the Social Security Act by adding Part C (Administrative Simplification), which requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards for certain transactions to enable health information to be exchanged more efficiently; and to achieve greater uniformity in its transmission. (Please refer to Public Law 104-191, Health Insurance Portability and Accountability Act of 1996, which you can find at **http://aspe.hhs.gov/admnsimp/pl104191.htm#1173** on the internet.)

Through the Affordable Care Act, Congress sought to promote implementation of electronic transactions and achieve cost reduction and efficiency improvements by creating more uniformity in the implementation of standard transactions and by mandating the adoption of a set of operating rules for each of the HIPAA transactions. In December 2011 Congressional testimony, the National Committee on Vital and Health Statistics (NCVHS) stated that the transition to Electronic Data Interchange (EDI) from paper has been slow and "disappointing." (You can find a copy of this testimony at **http://www.ncvhs.hhs.gov/** on the internet.)

Note: The same rules will also apply to Standard Paper Remittance (SPR), as Medicare reports the same standard codes in both electronic and paper formats of remittance advice.

The EFT & ERA Operating Rule Set includes the following rules:

(Please note that CR 8182 focuses only on rule numbers 3 and 4)

1. Phase III CORE 380 EFT Enrollment Data Rule;
2. Phase III CORE 382 ERA Enrollment Data Rule;
3. **Phase III Core 360 Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule**;
4. **CORE-required Code Combinations for CORE-defined Business Scenarios for the Phase III Core Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule**;
5. Phase III CORE 370 EFT & ERA Re-association (CCD+/835) Rule; and
6. Phase III CORE 350 Health Care Claim Payment/Advice (835) Infrastructure Rule.

HIPAA initially mandated the standard code sets that a health plan may use to explain to providers/suppliers how a claim/line has been adjudicated, and now the ERA/EFT Operating Rules

under the Affordable Care Act are mandating a standard use of those standard codes. The ERA/EFT Operating Rules mandate consistent and uniform use of Remittance Advice (RA) codes (Group Codes, Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC)) to mitigate confusion that may result in:

- Unnecessary manual provider follow-up;
- Faulty electronic secondary billing;
- Inappropriate write-offs of billable charges;
- Incorrect billing of patients for co-pays and deductibles, and/or
- Posting delay.

Business Scenarios

The CORE Phase III ERA/EFT Operating Rules define four Business Scenarios, and specify the maximum set of the standard codes that a health plan may use. This list will be updated and maintained by a CORE Task Group when the two code committees update the lists and/or when there is need for additional combinations based on business policy change and/or Federal/State Mandate.

The maximum set of CORE-defined code combinations to convey detailed information about the denial or adjustment for each business scenario is specified in the document: Committee on Operating Rules for Information Exchange (CORE®)-required Code Combinations for CORE-defined Business Scenarios for the Phase III CORE 360 Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule), that is an attachment to CR 8182. This list of code combinations will be updated by CAQH CORE on a regular basis, and for Medicare, the updated list will be a part of the recurring code update CR (published 4 times a year) in the future.

Additionally, you should be aware that Medicare is implementing the code combinations that relate to these four scenarios in October 2013, as follows:

Scenario #1 - Additional Information Required - Missing/Invalid/Incomplete Documentation
This scenario refers to situations in which additional documentation is needed from the billing provider or an ERA from a prior payer.

Scenario #2 - Additional Information Required – Missing/Invalid/Incomplete Data from Submitted Claim
This scenario refers to situations in which additional data are needed from the billing provider for missing or invalid data on the submitted claim, e.g., an 837 or D.0.

Scenario #3 - Billed Service Not Covered by Health Plan
This scenario refers to situations in which the billed service is not covered by the health plan.

Scenario #4 - Benefit for Billed Service Not Separately Payable
This scenario refers to situations in which the billed service or benefit is not separately payable by the health plan.

Finally, by October 7, 2013, the Medicare Remit Easy Print (MREP) and PC Print software will be modified as necessary.

Additional Information

The official instruction, CR8182, issued to your MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1291OTN.pdf on the CMS website You will find a copy of the document: Committee on Operating Rules for Information Exchange (CORE®)-required Code Combinations for CORE-defined Business Scenarios for the Phase III CORE 360 Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule) as an attachment to that CR.

If you have any questions, please contact your MAC at their toll-free number, which may be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.

News Flash - Flu Season Isn't Over – Continue to Recommend Vaccination - While each flu season is different, flu activity typically peaks in February. Yet, even in February, the flu vaccine is still the best defense against the flu. The CDC recommends yearly flu vaccination for everyone 6 months of age and older; and although anyone can get the flu, adults 65 years and older are at greater risk for serious flu-related complications that can lead to hospitalization and death. Every office visit is an opportunity to check your patients' vaccination status and encourage flu vaccination when appropriate. And getting vaccinated is just as important for health care personnel who can get sick with the flu and spread it to family, colleagues and patients. Be an example by getting your flu vaccine and know that you're helping to reduce the spread of flu in your community. Note: influenza vaccines and their administration fees are covered Part B benefits. Influenza vaccines are NOT Part D-covered drugs. *For More Information:*

- **2012-2013** Seasonal Influenza Vaccines Pricing.
- MLN Matters® Article MM8047, "Influenza Vaccine Payment Allowances - Annual Update for 2012-2013 Season."
- CMS Medicare Learning Network® 2012-2013 Seasonal Influenza Virus Educational Products and Resources and CMS Immunizations web pages for information on coverage and billing.
- HealthMap Vaccine Finder – a free, online service where users can find nearby locations offering flu vaccines as well as other vaccines for adults.
- The CDC's website offers a variety of provider resources for the 2012-2013 flu season.