

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



The Medicare Billing Certificate Program for Part B Providers" Web-Based Training Program (C00164) is revised and is now available. This WBT is designed to provide education on Part B of the Medicare program. It includes required web-based training courses and readings and a helpful list of resources. Upon successful completion of this program, you will receive a certificate in Medicare billing for Part B providers from the Centers for Medicare & Medicaid Services. To access the WBT, go to <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/index.html> and click on "Web-Based Training Courses" under "Related Links" at the bottom of the web page.

MLN Matters® Number: MM8365

Related Change Request (CR) #: CR 8365

Related CR Release Date: August 16, 2013

Effective Date: January 1, 2014

Related CR Transmittal #: R12810TN

Implementation Date: January 6, 2014

Implement Operating Rules - Phase III ERA EFT: CORE 360 Uniform Use of Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) Rule - Update from CAQH CORE

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 8365, from which this article is taken, instructs Medicare contractors and Shared System Maintainers (SSM) to use (effective January 1, 2014) the May 24, 2013 update to the Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information

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Exchange (CORE) Phase III CORE 360 Uniform Use of Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) (835) Rule CORE-required Code Combinations for CORE-defined Business Scenarios, version 3.0.2.

Background

On August 7, 2012, the Department of Health and Human Services (HHS) announced adoption of 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. (Refer to <http://www.hhs.gov/news/press/2012pres/08/20120807a.html> on the Centers for Medicare & Medicaid Services (CMS) website). In CR8182, released on May 9, 2013, CMS instructed Medicare contractors to implement this rule set by January 6, 2014. (You can find the associated MLN Matters® Article, MM8182 “Standardizing the Standard - Operating Rules for Code Usage in Remittance Advice” at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8182.pdf> on the CMS website.)

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

- 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:

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

- 4) Phase III CORE 370 EFT & ERA Re-association (CCD+/835) Rule; and
- 5) Phase III CORE 350 Health Care Claim Payment/Advice (835) Infrastructure Rule.

The Health Insurance Portability and Accountability Act (HIPAA) initially mandated the standard code sets that a health plan may use to explain to providers/suppliers how a claim or service has been adjudicated, and now the ERA/EFT Operating Rules under the Affordable Care Act are mandating 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

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Business Scenarios

The CORE Phase III ERA/EFT Operating Rules define four Business Scenarios and specify the maximum set of the standard code combinations 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 of existing codes based on business policy change and/or Federal/State Mandate.

CR8365, from which this article is taken, focuses on rule 3, and instructs Medicare contractors and Shared System Maintainers (SSM) to use (to be effective January 1, 2014, and to be implemented by January 6, 2014) the May 24, 2013 updated CORE Combination Lists in the document: "CAQH Committee on Operating Rules for Information Exchange (CORE) Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule CORE-required Code Combinations for CORE-defined Business Scenarios," version 3.0.2 (which you will find as an attachment to CR8365).

The following are the CORE-defined Claim Adjustment/Denial Business Scenarios and Descriptions:

Scenario #1: Additional Information Required - Missing/Invalid/Incomplete Documentation

This scenario refers to situations where 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

Refers to situations where additional data are needed from the billing provider for missing or invalid data on the submitted claim, e.g., an 837 or D.O.

Scenario #3: Billed Service Not Covered by Health Plan

Refers to situations where the billed service is not covered by the health plan.

Scenario #4: Benefit for Billed Service Not Separately Payable

Refers to situations where the billed service or benefit is not separately payable by the health plan.

Medicare is implementing the code combinations per the ERA/EFT Operating Rules in 2 releases (July and October 2013) that relate to these 4 scenarios (per CR 8182), and is adding the updates to CORE CODE Combinations (per CR8365), effective January 1, 2014. Finally, the Medicare Remit Easy Print (MREP) and PC Print, will be updated if needed, by January 6, 2014.

Additional Information

The official instruction, CR8365 issued to your Medicare contractor regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R12810TN.pdf> on the CMS website.

If you have any questions, please contact your Medicare contractor 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.

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