DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

MLN Matters® Number: MM9681 Revised	**Related Change Request (CR) #: CR 9681**
Related CR Release Date: January 6, 2017	**Effective Date: April 1, 2017**
Related CR Transmittal #: R1770OTN	**Implementation Date: April 3, 2017**

Modifications to the National Coordination of Benefits Agreement Crossover Process

Note: This article was revised on January 9, 2017, to reflect the revised CR9681 issued on January 9. In the article, references to Type of Bill 82x are deleted from the last paragraph of the Background Section. In addition, the CR release date, transmittal number, and the Web address of CR9681 are revised. All other information remains the same.

Provider Types Affected

This MLN Matters® Article is intended for providers, including hospices, submitting institutional claims to Medicare Administrative Contractors (MACs) requiring Coordination of Benefits (COB) for services provided to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 9681 modifies Medicare's Part A claims processing system to, among other things:

- Always ensure that a Remittance Advice Remark Code (RARC) accompanies claim denials tied to Claims Adjustment Reason Code (CARC) 16, as required.
- Prevent duplicate entry of hospital day counts expressed as value codes (for example, value code 80, 81, 82).
- Prevent reporting of Present on Admission (POA) indicators on outpatient Coordination of Benefits (COB) facility claims.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2015 American Medical Association. All rights reserved.

Make sure your billing staff is aware of these changes.

Background

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. Medicare routinely reports 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 requirements. Medicare also includes 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, MACs are not always including a valid and relevant RARC in the 2320 MIA field when they deny Medicare claims. Medicare crossover claims are often being rejected by supplemental payers as a consequence. 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....." CR9681 will ensure that at least one informational RARC is provided to comply with HIPAA and CAHQ/CORE requirements.

The Part A system is producing instances of duplicated hospital day counts on outbound 837 institutional COB/crossover claims. CR9681 remedies this situation. **Important:** Hospital billing staffs should avoid entering hospital day counts via Direct Data Entry (DDE) screens.

Lastly, at present there is no editing with the Part A system to prevent the entry of a POA indicator on incoming outpatient facility claims. CR9681 remedies this issue by returning to the provider (RTP) any outpatient claim (type of bill other than 11x, 18x, 21x, and 41x) that contains a POA indicator. **Important:** Billing vendors for hospitals should make it a practice to only include POA indicators on 11x, 18x, 21x, and 41x type of bill (TOB) claims submitted to Medicare.

Additional Information

The official instruction, CR9681, issued to your MAC regarding this change is available at **https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R1770OTN.pdf**.

If you have any questions, please contact your MAC at their toll-free number. That number is available at **https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-**

Disclaimer
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2015 American Medical Association. All rights reserved.

Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/.

Document History

- January 9, 2017 - This article was revised on January 9, 2017, to reflect the revised CR9681 issued on January 9. In the article, references to Type of Bill 82x are deleted from the last paragraph of the Background Section. In addition, the CR release date, transmittal number, and the Web address of CR9681 are revised.
- October 31, 2017 - Initial Issuance

Disclaimer
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2015 American Medical Association. All rights reserved.