CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1318	**Date: November 15, 2013**
	Change Request 8297

SUBJECT: Use of Claim Adjustment Reason Code 23

I. SUMMARY OF CHANGES: It has been brought to our attention that a recent modification in one of the Claim Adjustment Reason Codes (CARCs) has resulted in some issues for Medicare. In April, 2013 Change Request (CR) 8154 was implemented that instructed to use CARC 23 - The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA) that has been modified to include the instruction that it must be used with Group Code OA - Other Adjustment. This is also a part of CAQH CORE developed ERA/EFT Operating Rules under Affordable Care Act. This CR instructs the Shared System Maintainers (SSMs) how to use CARC 23 to report prior payer adjudication in case of a secondary claim.

EFFECTIVE DATE: April 1, 2014
IMPLEMENTATION DATE: April 7, 2014 - Full implementation for FISS and MCS. Analysis & Design for VMS; July 7, 2014 - Full Implementation for VMS

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 Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

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 obliged 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
**Unless otherwise specified, the effective date is the date of service.*

One-Time Notification

Pub. 100-20	Transmittal: 1318	Date: November 15, 2013	Change Request: 8297

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I. GENERAL INFORMATION

A. Background: Medicare beneficiaries may have multiple coverages that come either before or after Medicare. If per Coordination Of Benefits (COB), Medicare is the secondary payer, the adjudication process has to take how the previous payer(s) has/have adjudicated into consideration and report on the Remittance Advice (RA) accordingly. The implementation guide for the current Electronic Remittance Advice (ERA) - ASC X12 Transaction 835 version 5010 - has explicit instruction in the Front Matter, Section 1.10.2.13 (Secondary Payment Reporting Consideration):

"Report the "impact" in the appropriate claim or service level CAS segment with reason code 23 (Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments.) and Claim Adjustment Group Code OA (Other Adjustment). Code OA is used to identify this as an administrative adjustment.....It is essential that any secondary payer report in the remittance advice only the primary amount that has actually impacted their secondary payment. In many cases, this "impact" is less than the actual primary payment" When this happens, reporting the actual payment would prevent the transaction from balancing."

Medicare does not have to report everything the previous payer has done, because that information is reported by the previous payer to the provider through the previous payer's RA. In order to generate and send a balanced Medicare RA and COB Claim, Medicare should report only the part of previous payer's adjudication that impacts Medicare calculation of payment and adjustments.

B. Policy: Medicare sends HIPAA compliant transactions

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
8297.1	FISS, MCS and VMS shall report the Medicare allowed amount in the appropriate claim or service level AMT segment using qualifier AU (claim level) or B6 (service level) in AMT01 Note: Do not need to do any additional work if the current process is already populating the AMT										X		

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
	segment correctly.												
8297.2	FISS, MCS and VMS shall report any patient responsibility for which patient is still responsible after coordination of benefits with the previous payer(s) with Group Code "PR' and the appropriate Claim Adjustment Reason Code (for example: 1 - Deductible Amount, 2 - Coinsurance Amount). Note: No additional work is needed if the current process reports the patient reponsibilty with correct Group Code - PR and with correct claim adjustment reason and remittance advice remark code if appropriate.									X	X		
8297.3	FISS, MCS and VMS shall report any further adjustment taken by Medicare as a result of previous payer(s) payment and/or adjustment(s) with Group Code OA and Claim Adjustment Reason Code 23. Note: OA 23 shall be reported on the remittance advice and the COB claim only once showing the total “impact”amount at the claim level or once at each service level as appropriate.								X	X	X		
8297.4	Contractors shall test 835 files generated out of their UAT systems through to their translators to ensure that Shared System changes made as a result of this CR do not cause translation failures. Note: CEDI shall support DME MACs as needed with their testing efforts.	X	X		X	X	X	X					CEDI
8297.5	FISS, MCS, and VMS shall ensure that all claims adjudicated at the service line level and that are created for outbound COB purposes will balance as follows: • Service line paid amounts (2430 SVD-02) when added to all service line adjustment amounts (2430 CAS) will equal the line item charge for the service line (loop 2400). Note: Do not need to do any additional work if the current process is already balancing at the service										X		

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
	line level.												

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility							
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Other
		A	B	HHH					
8297.6	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 one week of the availability of the provider education 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		X	X	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:
	N/A

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

V. CONTACTS

Pre-Implementation Contact(s): Sumita Sen, Sumita.Sen@cms.hhs.gov , Brian Pabst, Brian.Pabst@cms.hhs.gov (For BR 8297.5)

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:
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