CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1187	**Date: February 8, 2013**
	Change Request 8182

SUBJECT: Standardizing the standard - Operating Rules for code usage in Remittance Advice

I. SUMMARY OF CHANGES: This Change Request (CR) instructs the Medicare Administrative Contractors (MACs) and the Shared System Maintainers (SSMs) to implement Operating Rules for code usage in Electronic Remittance Advice (ERA) under the Patient Protection and Affordable Care Act. The same rules will apply to Standard Paper Remittance (SPR), and Medicare will report the same standard codes in both electronic and paper formats of remittance advice.

EFFECTIVE DATE: Other (July 1, 2013 - Analysis & Design; October 1, 2013 – Full Implementation)
IMPLEMENTATION DATE: Other (July 1, 2013 - Analysis & Design; October 7, 2013 - Full Implementation)

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	

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs):
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.*

Attachment - One-Time Notification

Pub. 100-20	Transmittal: 1187	Date: February 8, 2013	Change Request: 8182

SUBJECT: Standardizing the standard - Operating Rules for code usage in Remittance Advice

EFFECTIVE DATE: Other (July 1, 2013 - Analysis & Design; October 1, 2013 – Full Implementation)

IMPLEMENTATION DATE: Other (July 1, 2013 - Analysis & Design; October 7, 2013 - Full Implementation)

I. GENERAL INFORMATION

A. Background: HHS adopted the Phase III Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) EFT & ERA Operating Rule Set that must be implemented by January 1, 2014 under Patient Protection and Affordable Care Act of 2010. Health Insurance Portability and Accountability Act (HIPAA) amended the Act by adding Part C—Administrative Simplification—to Title XI of the Social Security Act, requiring the Secretary of the Department of Health and Human Services (HHS) (the Secretary) to adopt standards for certain transactions to enable health information to be exchanged more efficiently and to achieve greater uniformity in the transmission of health information. More recently, the National Committee on Vital and Health Statistics (NCVHS) reported to the Congress that the transition to Electronic Data Interchange (EDI) from paper has been slow and dissapointing. 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. This was done by mandating the adoption of a set of operating rules for each of the HIPAA transactions. The Affordable Care Act defines operating rules and specifies the role of operating rules in relation to the standards.

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;

(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 Reassociation (CCD+/835) Rule; and (6) Phase III CORE 350 Health Care Claim Payment/Advice (835) Infrastructure Rule; and

(6) Phase III CORE 350 Health Care Claim Payment/Advice (835) Infrastructure Rule.

This CR focuses on #s 3 and 4 under Phase III Core 360 Operating Rule.

The ERA/EFT Operating Rules mandate consistent and uniform use of RA codes - Group Code, CARC and RARC - to mitigate the 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

- Posting delay

Health Innsurance Portability and Accountability Act (HIPAA) mandated the standard code sets that may be used by a healthplan to communicate to providers/suppliers explaining how a claim/line has been adjudicated , and now the ERA/EFT Operating Rules under ACA are mandating a standard use of those standard codes. The CORE Phase III ERA/EFT Operating Rules define 4 Business Scenarios and specify the maximum set of the standard codes that a healthplan may use. This list will be updated and maintained by A CORE Task Group when the 2 code committees update the lists and/or when there is need for additional combinations based on business policy change and/or Federal/State Mandate.

CORE-defined Claim Adjustment/Denial Business Scenarios and Description:

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

Refers to situations where additional documentation is needed from the billing provider or an ERA from a prior payer. The maximum set of CORE-defined code combinations to convey detailed information about the denial or adjustment for this business scenario is specified in*CORE-required Code Combinations for CORE-defined Business Scenarios.doc.*

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.0. The maximum set of CORE-defined code combinations to convey detailed information about the denial or adjustment for this business scenario is specified in*CORE-required Code Combinations for CORE-defined Business Scenarios.doc.*

Scenario #3: Billed Service Not Covered by Health Plan

Refers to situations where the billed service is not covered by the health plan. The maximum set of CORE-defined code combinations to convey detailed information about the denial or adjustment for this business scenario is specified in*CORE-required Code Combinations for CORE-defined Business Scenarios.doc.*

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. The maximum set of CORE-defined code combinations to convey detailed information about the denial or adjustment for this business scenario is specified in*CORE-required Code Combinations for CORE-defined Business Scenarios.doc.*

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. These code combinations may or may not match what Medicare has been currently reporting. In order to be compliant with ERA/EFT Operating Rules as adopted under Section 1104 of the Affordable Care Act, the MACs must use code combinations that are included in the list developed by CAQH CORE and attached to this CR. When the contractors are analyzing and comparing the code combinations being currently used with this list, they may identify code combinations that are most appropriate to explain specific adjustments that are not included in this list. In such cases, Medicare will try to get them added to CAQH CORE list working through the CORE Code Combination Task Group. There will be a Technical Direction Letter (TDL) sent later instructing the MACs how to send their requests to CMS to add code combinations to the CORE list. CAQH CORE has agreed to update their

list of code combinations when the 2 standard code sets are updated – 3 times a year. In addition to these regular updates, CAQH CORE will also do an annual "Market Based Update" that would include new code combinations of existing codes needed to address new business needs and/or due to new Federal/State/local mandate. The recurring Remittance Advice Remark and Claim Adjustment Reason code CR will have the updated CORE list as attachment(s). .

B. Policy: Medicare implements HIPAA transactions and related Operating Rules to be compliant.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement.

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
8182.1	Contractors and Shared System Maintainers shall report only the code combinations that are listed in the attached document under Scenario #1. This requirement shall be implemented by October 7, 2013. Scenario #1: Additional Information Required – Missing/Invalid/Incomplete Documentation	X	X	X	X	X	X	X	X	X		
8182.2	Contractors and Shared System Maintainers shall report only the code combinations that are listed in the attached document under Scenario #2. This requirement shall be implemented by October 7, 2013. Scenario #2: Additional Information Required – Missing/Invalid/Incomplete Data from Submitted Claim	X	X	X	X	X	X	X	X	X		
8182.3	Contractors and Shared System Maintainers shall report only the code combinations that are listed in the attached document under Scenario #3. This requirement shall be implemented by October 7, 2013. Scenario #3: Billed Service Not Covered by Health Plan	X	X	X	X	X	X	X	X	X		
8182.4	Contractors and Shared System Maintainers shall report only the code combinations that are listed in the attached document under Scenario #4. This requirement shall be implemented by October 7, 2013. Scenario #4: Benefit for Billed Service Not Separately Payable	X	X	X	X	X	X	X	X	X		

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
8182.5	ViPs and FISS shall update Medicare Remit Easy Print (MREP) and PC Print, if needed, per attached. This requirement shall be implemented by October 7, 2013.							X		X		
8182.6	FISS, MCS and VMS shall complete analysis and provide edit lists to the MACs for their review and update of code combinations per BRs 1, 2, 3, and 4 by July 1, 2013.							X	X	X		
8182.7	FISS, MCS and VMS shall generate a monthly report to identify code combinations that have been used by MACs that are outside of the current code combinations list per Operating Rules, and shall share them with the MACs and CMS starting with the month of October, 2013. NOTE: These reports will identify the code combinations, MACs and the dates for using these additional combinations.							X	X	X		

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility						
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Other
		Part A	Part B					
8182.8	MLN Article : A provider education article related to this instruction will be available at http://www.cms.hhs.gov/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	X	X	X	X	X	X	

Number	Requirement	Responsibility						
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Other
		Part A	Part B					
	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.							

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A
Use "Should" to denote 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): sumita sen, sumita.sen@cms.hhs.gov

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):
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

Section B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS do 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.