CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 10236	**Date: July 31, 2020**
	Change Request 11857

SUBJECT: Update to the IOM Publication (Pub) 100-04, Medicare Claims Processing Manual, Chapters 1, 6, 8, 17, 20, 22, 24, and 31 Referencing the Active Universal Resource Locators (URLs) for the Washington Publishing Company (WPC) and the ASC X12 Organizations, and Updates to the HIPAA Eligibility Transaction System (HETS)

I. SUMMARY OF CHANGES: This Change request makes updates to Chapters 1, 6, 8, 17, 20, 22, 24, and 31 of the Medicare Claims Processing Manual Pub. 100-04.

EFFECTIVE DATE: August 31, 2020
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: August 31, 2020

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
R	01/01.1 – Remittance Advice Coding Used in this Manual
R	01/02.1.1 - HIPAA Standards for Claims
R	01/02.1.2 - Where to Purchase HIPAA Standard Implementation Guides
R	01/30.3.7 - Billing for Diagnostic Tests (Other Than Clinical Diagnostic Laboratory Tests) Subject to the Anti-Markup Payment Limitation - Claims Submitted to A/B/MACs
R	06/40.6 - Total and Noncovered Charges
R	08/80.2 -- General A/B MAC (A) Bill Processing Procedures for Method I Home Dialysis Services
R	08/140.3 -- Data Elements Required on Claim for Monthly Capitation Payment
R	17/70 -- Claims Processing Requirements - General
R	20/140.1 -- Billing for Supplies and Drugs Related to the Effective Use of DME
R	22/40 - Electronic Remittance Advice - ERA or ASC X12 835
R	22/40.6 – ASC X12 835 Implementation Guide (IG) or Technical Report 3 (TR3)
R	22/60.2 – Claim Adjustment Reason Codes
R	24/40.1.1 - HIPAA Transaction Standards as Designated by CMS
R	24/50.2 - Translators
R	24/60.4 - Remittance Advice and Standard Paper Remittances
R	24/60.6 - Health Care Provider Taxonomy Code (HPTC) Requirements
R	31/10.2 -Eligibility Connectivity Workflow
R	31/20 - ASC X12 276/277 Claims Status Request/Response Transaction Standard
R	31/20.7 – Health Care Claim Status Category Codes and Health Care Claim Status Codes for Use with the Health Care Claim Status Request and Response ASC X12 276/277 Claim Status Request and Response

III. FUNDING:

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 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.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal:10236	Date: July 31, 2020	Change Request: 11857

SUBJECT: Update to the IOM Publication (Pub) 100-04, Medicare Claims Processing Manual, Chapters 1, 6, 8, 17, 20, 22, 24, and 31 Referencing the Active Universal Resource Locators (URLs) for the Washington Publishing Company (WPC) and the ASC X12 Organizations, and Updates to the HIPAA Eligibility Transaction System (HETS)

EFFECTIVE DATE: August 31, 2020
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IMPLEMENTATION DATE: August 31, 2020

I. GENERAL INFORMATION

A. Background: This Change Request (CR) is updating Pub. 100-04, Chapters 1, 6, 8, 17, 20, 22, 24, and 31, in multiple Sections referencing the Washington Publishing Company (WPC) and ASC X12 Universal Resource Locator (URL) for these organizations, and the HIPAA Eligibility Transaction System (HETS) in Chapter 31, Section 10.2, of the Medicare Claims Processing manual.

B. Policy: No policy changes.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11857.1	Medicare Administrative Contractors (MACs) and Shared System Maintainers (SSMs) shall refer to IOM Pub 100-04, Chapters 1, 6, 8, 17, 20, 22, 24, and 31 for updates to references for the active URLs for the Washington Publishing Company and the ASC X12 organizations.	X	X	X	X					CEDI
11857.2	Medicare Administrative Contractors (MACs) shall refer to IOM Pub 100-04, Chapter 31, Section 10.2 -- Eligibility Connectivity Workflow for reference to the active URL for the HIPAA Eligibility Transaction System (HETS) Help site.	X	X	X	X					CEDI

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility

		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes 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): Shannon Williams, 410-786-4089 or shannon.williams@cms.hhs.gov , Anna Meisheid, 410-786-0588 or anna.meisheid@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: 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 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.

ATTACHMENTS: 0

Medicare Claims Processing Manual

Chapter 1 - General Billing Requirements

01.1 – Remittance Advice Coding Used in this Manual

(Rev. 10236, Issued: 07-31-2020, Effective: 08-31-2020, Implementation: 08-31-2020)

When Medicare denies coverage or adjusts the payment amount for items or services, these actions are documented using codes reported on the provider's remittance advice. Medicare, like all other health insurance payers, uses remittance advice codes in combination to create one message. This combination includes a Claim Adjustment Group Code (Group Code) and a Claim Adjustment Reason Code (CARC). Frequently, payers also use one or more Remittance Advice Remark Codes (RARC) to add additional detail. RARC coding is optional unless the CARC definition requires an accompanying RARC, so RARCs may not appear on all remittance advice messages.

Each of the codes in the message communicates different information:

- Group Codes assign financial responsibility to the provider or the beneficiary
- CARCs communicate the general reason why the payment is different from the billed amount
- RARCs, when used in combination with CARCs, provide additional or more specific payment adjustment information

In certain cases, RARCs may also be used alone to provide information unrelated to the difference between the amount billed and the amount paid. In these cases, the RARC definition always begins with the word "Alert."

Remittance advice codes are identified in standard code sets that are used by all payers, as required by HIPAA. Since the definitions of the codes are an industry standard, the instructions in this manual refer only to the code values. Providers and contractors can access the definitions of the codes at the official Washington Publishing Company website.

Section 1171 of the Social Security Act requires a standard set of operating rules to regulate the health insurance industry's use of electronic data interchange (EDI) transactions. Operating Rule 360: Uniform Use of CARCs and RARCs, regulates the way in which group codes, CARCs and RARCs may be used. The rule requires specific codes which are to be used in combination with one another if one of the named business scenarios applies. This rule is authored by the Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE).

Medicare and all other payers must comply with the CAQH CORE-developed code combinations. The business scenario for each payment adjustment must be defined, if applicable, and a valid code combination selected for all remittance advice messages. Providers and contractors can access the business scenarios and code combinations at: caqh.org/CORECodeCombinations.php. When remittance advice messages are used to explain payments to providers, Medicare Summary Notice (MSN) messages are used to explain payments to beneficiaries.

In order to provide remittance advice codes and MSN messages consistently throughout the Medicare Claims Processing Manual, the one of the following standard language statements will be included as necessary.

- If the CARC/RARC being reported is included in the CAQH CORE list of valid combinations:

"The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario [Insert Business Scenario number].

Group Code: [Insert Group Code]
CARC: [Insert CARC number or N/A if the RARC is an Alert message]
RARC: [Insert RARC number(s) or N/A if a RARC is not needed]
MSN: [Insert MSN message number(s)]"

- If the CARC is not included in the CAQH CORE publication and therefore, standard business scenarios do not apply:

  "The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. The CARC below is not included in the CAQH CORE Business Scenarios.

  Group Code: [Insert Group Code]
  CARC: [Insert CARC number or N/A if the RARC is an Alert message]
  RARC: [Insert RARC number(s) or N/A if a RARC is not needed]
  MSN: [Insert MSN message number(s)]"

02.1.1 - HIPAA Standards for Claims

(Rev. 10236, Issued: 07-31-2020, Effective: 08-31-2020, Implementation: 08-31-2020)

The standards adopted under HIPAA include both a transaction standard and an implementation guide. The following are the claims transactions and the implementation guides adopted as standards under HIPAA:

Standard Claim Transaction	Short Reference	Implementation Guide	Type of Claim
ASC X12 Health Care Claim: Professional (837)	ASC X12 837 professional claim	ASC X12 Standards for Electronic Data Interchange Technical Report Type 3—Health Care Claim: Professional (837)	Professional services and supplies, including retail pharmacy
ASC X12 Health Care Claim: Institutional (837)	ASC X12 837 institutional claim	ASC X12 Standards for Electronic Data Interchange Technical Report Type 3—Health Care Claim: Institutional (837)	Institutional
Telecommunication Standard, National Council for Prescription Drug Programs and equivalent Batch Standard, National Council for Prescription Drug Programs	Depending upon context: NCPDP claim; NCPDP transaction; NCPDP batch transaction; NCPDP batch claim	Telecommunication Standard Implementation Guide and equivalent Batch Standard Implementation Guide, National Council for Prescription Drug Programs.	Retail pharmacy professional services and supplies; retail pharmacy drugs

Claims sent electronically to Medicare must abide by the HIPAA standards listed above. The current versions of these HIPAA standards are listed in chapter 24 of this manual. More information about HIPAA can be found at www.cms.gov, under the "Regulations and Guidance" tab. More information about these transactions and implementation guides can be found, as appropriate, at the official ASC X12 website and www.NCPDP.org.

In addition, chapter 24 of this manual provides more information regarding Medicare's requirements for electronic data interchange (EDI), such as EDI enrollment and trading partner agreements.

Note that HIPAA standard implementation guides provide comprehensive directions regarding how to submit a claim on the transactions they support. Therefore, there is no separate guidance in this claim processing manual as to how to submit a claim using these transactions. However, there may be situations where the Medicare requirements require additional clarification, description, or guidance. In such cases, there will be additional instructions in the appropriate subject area section.

02.1.2 - Where to Purchase HIPAA Standard Implementation Guides

(Rev. 10236, Issued: 07-31-2020, Effective: 08-31-2020, Implementation: 08-31-2020)

ASC X12 implementation guides (technical report 3s) may be purchased from the official Washington Publishing Company website. NCPDP implementation guides may be purchased from the NCPDP at www.NCPDP.org

30.3.7 - Billing for Diagnostic Tests (Other Than Clinical Diagnostic Laboratory Tests) Subject to the Anti-Markup Payment Limitation - Claims Submitted to A/B/MACs

(Rev. 10236, Issued: 07-31-2020, Effective: 08-31-2020, Implementation: 08-31-2020)

A. General

A physician or other supplier may bill and receive payment for the technical component (TC) or professional component (PC) of a diagnostic test (other than clinical diagnostic laboratory test) that is performed by a physician or other supplier with whom the billing physician or other supplier does not share a practice. Reimbursement for that service is subject to the anti-markup payment limitation. If a physician or other supplier's bill or a request for payment includes a charge for a diagnostic test (other than a clinical diagnostic laboratory test) which the physician or other supplier did not personally perform or supervise, then payment for the test may not exceed the lesser of:

- The performing physician's net charge to the billing physician or other supplier (net any discounts);
- The billing physician's actual charge; or
- The fee schedule amount that would be allowed for the test if the performing physician or other supplier billed directly.

(See §30.2.9 of this chapter for additional information.)

For payment to be made, the physician who acquires the TC or PC of a diagnostic test from an outside source must identify the performing physician or other supplier on the claim. (The billing physician or other supplier should maintain a record of the performing physician or other supplier's NPI in the clinical record for auditing purposes.)

The billing physician or other supplier must also indicate on the claim that the test is subject to the anti-markup payment limitation.

See the guidelines at the official Washington Publishing Company website for how to show this on electronic claims.

If using the CMS-1500 paper claim form:

- In item 20 check "yes" to indicate the test is subject to the anti-markup payment limitation and enter the amount the performing physician or other supplier charged.
- In item 32 enter the name, address, and NPI of the performing physician or supplier. If the performing physician provides the service outside the A/B MAC (B) jurisdiction where the billing physician is located, the billing physician must submit its own NPI with the name, address, and ZIP code of the performing physician or other supplier.

No payment may be made to the physician without this information unless the statement "No anti-markup tests are included" is annotated on the claim.

NOTE: If the billing physician performs only the TC or the PC and wants to bill for both components of the diagnostic test, the TC and PC must be reported as separate line items if billing electronically or on separate claims if billing on paper (CMS-1500). Global billing is not allowed unless the billing physician or other supplier performs both components.

Effective for claims submitted with a receipt date on and after October 1, 2015, the billing physician or supplier must report the name, address, and NPI of the performing physician or supplier in Item 32a of the CMS-1500 claim form (or its electronic equivalent) on anti-markup claims, even if the performing physician or supplier is enrolled in a different A/B MAC (B) jurisdiction. (See §10.1.1.2 for more information regarding claims filing jurisdiction.)

B. Unassigned Claims with Required Documentation

A physician or other supplier may not bill an individual an amount in excess of Medicare's payment, except for any deductible and coinsurance, for the TC or PC of a diagnostic test that is subject to the anti-markup payment limitation. A/B MACs (B) must notify physicians and other suppliers that they must indicate when a diagnostic test was acquired, identify the performing physician or other supplier, and show the amount the performing physician or other supplier charged. The notification must inform physicians and other suppliers that they are prohibited by §1842(n)(3) of the Act from billing or collecting an amount in excess of Medicare's payment, except for the deductible and coinsurance. Excess amounts collected from the beneficiary must be repaid.

C. Unassigned Claims without Required Documentation

A physician may not bill a beneficiary:

- If the bill does not indicate who performed the test; and

- If the bill indicates that a separate physician or other supplier performed the test, it does not identify the performing physician or other supplier or does not include the amount the performing physician or other supplier charged.

The A/B MACs (B) notify the physician when a non-assigned claim for the TC or PC of a diagnostic test subject to the anti-markup payment limitation is received from either the physician or a beneficiary except when the physician submits an assigned claim and the beneficiary submits an unassigned duplicate claim. They use the following sample letter.

> Dear Doctor:
>
> We have received an unassigned claim for diagnostic tests furnished to the patient (Beneficiary Name), on (Date of Service). You are prohibited by §1842(n)(3) of the Social Security Act from billing or collecting any amount unless you indicate that "No anti-markup tests are included" or, if the diagnostic test was acquired, you indicate who performed the test and what the physician or other supplier charged you. Some or all of the required information is missing from your patient's claim. If you have collected any amount from

your patient, it must be refunded. This claim may be resubmitted if the required information is included.

D. Beneficiary Information Regarding Unassigned Claims

The A/B MACs (B) must notify the beneficiary that the physician is prohibited from:

- Billing the beneficiary when the necessary documentation is not supplied; and

- Billing or collecting an amount in excess of Medicare's payment, except for the deductible and coinsurance, when the required documentation is submitted.

(See chapter 21 of this manual, for MSN messages.)

Medicare Claims Processing Manual

Chapter 6 - SNF Inpatient Part A Billing and SNF Consolidated Billing

40.6 - Total and Noncovered Charges

(Rev. 10236, Issued: 07-31-2020, Effective: 08-31-2020, Implementation: 08-31-2020)

ASC X12 837 Institutional Claim

See the related implementation guide on the official Washington Publishing Company website.

Form CMS -1450

For each cost center for which a separate charge is billed (type of accommodation or ancillary), a revenue code is assigned and is entered on the claim with the related charges. On Form CMS-1450 the appropriate numeric revenue code is entered in FL 42 to explain each charge in FL 47.

Additionally, there is no fixed "Total" line in the charge area. Instead, revenue code "0001" is always entered last in FL 42. Thus, the adjacent charge entry, in FL 47, is the sum of charges billed. This is also the same line on which noncovered charges, if any, in FL 48, are summed.

The total charge for all services, covered and noncovered, will generally be shown. See §40.6.1 below, for certain exceptions. In the "noncovered charges" column (FL48) enter the amount of any noncovered charge except where:

- The A/B MAC (A) has notified the SNF that payment can be made under the limitation of liability provisions; and

- A payer primary to Medicare is involved. (See the Medicare Secondary Payer [MSP] Manual, Chapter 3, "MSP Provider Billing Requirements," and Chapter 4, "Contractor Prepayment Processing Requirements.")

Where a bill is submitted for a period including both covered and noncovered days (e.g., days submitted for noncovered level of care), the SNF must list the charges for noncovered days under noncovered charges.

Refer to the Medicare Claims Processing Manual, Chapter 25 for further information about completing the claim.

Medicare Claims Processing Manual
Chapter 8 - Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims

80.2 - General A/B MAC (A) Bill Processing Procedures for Method I Home Dialysis Services

(Rev. 10236, Issued: 07-31-2020, Effective: 08-31-2020, Implementation: 08-31-2020)

General instructions for completing the Form CMS-1450 are in Chapter 25. Instructions for completing the ASC X12 837institutional format are in the related implementation guide, available on the Washington Publishing Company's web site at the official Washington Publishing Company website.

Instructions in §§50 and 50.3, above, apply to provider reporting of ESRD home dialysis services under Method I.

All home dialysis patients must have chosen either Method I or Method II.

The A/B MAC (A) uses the method of election information provided in the "Method" field of CWF trailer 14 "ESRD Method Trailer" attached to the query response when an ESRD claim is submitted for approval.

If the beneficiary has elected Method I, the A/B MAC (A) pays the facility the composite rate plus any additional billable services.

If the beneficiary has elected Method II, the facility is not paid the composite rate or for home dialysis supplies and equipment. Payment is made only for support, backup, and emergency dialysis services.

140.3 - Data Elements Required on Claim for Monthly Capitation Payment

(Rev. 10236, Issued: 07-31-2020, Effective: 08-31-2020, Implementation: 08-31-2020)

On Form CMS-1500

A. Elements 1 through 13 of the Form CMS-1500 are completed in accordance with the regular instructions

B. Elements 14 through 20 of the Form CMS-1500 are omitted.

C. Element 32 must contain the name and address of the facility involved with the patient's maintenance care or training, and 32a must contain the facility NPI.

D. Element 21 must show the diagnosis. Indicate in Element 19 whether the patient is in training for self-dialysis.

E. Element 24A must show the dates of service during the month that are included in the MCP. The period includes the full calendar month the MCP physician or practitioner was responsible for the beneficiary's ESRD related care.

For the first month the beneficiary begins dialysis treatments, the first date the dialysis treatments begin through the end of the calendar month should be used as the dates of service.

For outpatient ESRD-related services furnished for less than a full month, per day as discussed in 140.2 (e.g. transient patients, partial month due to hospitalization, transplant, or death), the first and last date the physician or practitioner was responsible for the beneficiary's ESRD-related care during the month should be used as the dates of service. Non-continuous dates should be billed on separate claim lines, (e.g. 1/1/08 –

1/7/08 and 1/20/08 – 1/31/08). A separate monthly claim should be submitted when the duration of ESRD-related services, per day, overlaps two different months as discussed in 140.21 (e.g. August 15 - September 7).

F. The remainder of the Form CMS-1500 is completed in accordance with the general instructions.

On ASC X12 Professional Format

Instructions for completing the ASC X12 837 professional claim format are in the related implementation guide, available on the official Washington Publishing Company website.

Medicare Claims Processing Manual
Chapter 17 - Drugs and Biologicals

70 - Claims Processing Requirements - General
(Rev. 10236, Issued: 07-31-2020, Effective: 08-31-2020, Implementation: 08-31-2020)

A/B MACs (B) are billed with the ASC X12 837 professional claim format or, if approved, with the paper form CMS-1500. A/B MACs (A) are billed with the ASC X12 837 institutional claim format or, if approved, with the paper Form CMS-1450.

See Chapters 24, 25 and 26 for detailed claims processing requirements, including forms, data elements, and formats. See Chapters 21 and 22 for MSN and remittance record requirements. See the official Washington Publishing Company web site for information about ASC X12 formats and related training material.

In addition to requirements applicable to all claims the following apply to drug claims.

- On claims to A/B MACs (A) the drug is identified by the appropriate HCPCS code for the drug administered and billed under revenue code 0636 unless specific instruction states otherwise;
- On claims to A/B MACs (B) the drug is identified by HCPCS code;
- All drugs, including Prodrugs, are reported to DME MACs by National Drug Code (see §80.1.2);
- Where HCPCS is required, units are entered in multiples of the units shown in the HCPCS narrative description. For example, if the description for the code is 50 mg, and 200 mg are provided, units are shown as 4; See examples below.
- Where the NDC is required units are entered in multiples of the units shown in the NDC label description. For example, if the description for the code is 50 mg., and 200 mg are provided, units are shown as 4;
- If the units provided exceed the size of the units field, or require more characters to report than spaces available in the format, repeat the HCPCS or NDC code on multiple lines until all units can be reported;
- Covered administration codes for injections may be billed to the A/B MAC (B) and A/B MAC (A) in addition to billing for the drug. The drug maximum payment allowance is for the drug alone. However, if payment is under a PPS, such as OPPS, the injection would be included in the APC rate.

The examples below include the HCPCS code and indicate the dosage amount specified in the descriptor of that code. Facilities use the units field as a multiplier to arrive at the total dosage amount.

EXAMPLE 1

HCPCS	J7189
Drug	Factor VIIa
Dosage	1 mcg

Actual dosage: 13,365 mcg

On the bill, the facility shows J7189 and 13,365 in the units field (13,365 mcg divided by 1 mcg = 13,365 units).

NOTE: The process for dealing with one international unit (IU) is the same as the process of dealing with one microgram.

EXAMPLE 2

HCPCS	J9355
Drug	Trastuzumab
Dosage	10 mg

Actual dosage: 140 mg

On the bill, the facility shows J9355 and 14 in the units field (140 mg divided by 10mg = 14 units).

When the dosage amount is greater than the amount indicated for the HCPCS code, the facility rounds up to determine units. When the dosage amount is less than the amount indicated for the HCPCS code, use 1 as the unit of measure.

EXAMPLE 3

HCPCS	J3100
Drug	Tenecteplase
Dosage	50 mg

Actual Dosage: 40 mg

The provider would bill for 1 unit, even though less than 1 full unit was furnished.

See §10 for a description of drug payment rules.

Medicare Claims Processing Manual
Chapter 20 - Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

140.1 - Billing for Supplies and Drugs Related to the Effective Use of DME
(Rev. 10236, Issued: 07-31-2020, Effective: 08-31-2020, Implementation: 08-31-2020)

Suppliers and providers bill supplies that are necessary for the effective use of DME, including drugs, with the appropriate HCPCS code identifying the supply. HHAs must also report revenue code 0294, "Supplies/Drugs for DME Effectiveness."

Suppliers and providers, other than HHAs, bill supplies and drugs (not including drugs that are necessary for the effective use of implanted DME) that are necessary for the effective use of DME to the DME MACs. HHAs bill the A/B MACs (HHH).

Suppliers and providers, other than HHAs, bill for drugs that are necessary for the effective use of implanted DME (HCPCS codes E0751, E0753, E0782, and E0783) to the A/B MAC (B). HHAs bill the A/B MAC (HHH).

The A/B MACs (HHH) contact the DME MAC or A/B MAC (B) as necessary to determine drug prices.

The DME MACs must:

- accept NDC codes for all drugs billed in the NCPDP format;
- accept NDC codes for oral anti-cancer drugs billed in the ASC X12 837 professional claim format, NCPDP format, and paper Form CMS-1500;
- accept HCPCS for all other drugs billed in the ASC X12 837 professional claim format and paper Form CMS-1500 and
- return as unprocessable claims submitted with an invalid NDC using the appropriate Remittance Advice Remark Code..

See the official Washington Publishing Company website for a current list of the Remittance Advice Remark Codes.

Medicare Claims Processing Manual
Chapter 22 - Remittance Advice

40 - Electronic Remittance Advice - ERA or ASC X12 835
(Rev. 10236, Issued: 07-31-2020, Effective: 08-31-2020, Implementation: 08-31-2020)

Electronic Remittance Advice (ERA) transactions must be produced in the current HIPAA compliant ASC X12 835 version /5010. Directions for version updates are posted when necessary in CMS Change Request (CR) instructions issued by CMS. Refer to the official Washington Publishing Company website for implementation guides, record formats, and data dictionaries for the ASC X12 835

Shared systems maintainers must provide appropriate provider file structures and switching mechanisms so that MACs can select and generate the ASC X12 835 and/or the automated clearing house (ACH) format when electronic funds transfer (EFT) applies. See the implementation guides for further information on the abbreviated ASC X12 835 and use of the ASC X12 835 for EFT.

Changes to content and format of ERAs may not be made by individual MACs. Changes will be made only by shared system maintainers, and then, only as directed by CMS.

40.6 – ASC X12 835 Implementation Guide (IG) or Technical Report 3 (TR3)
(Rev. 10236, Issued: 07-31-2020, Effective: 08-31-2020, Implementation: 08-31-2020)

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires that Medicare, and all other health insurance payers covered under HIPAA comply with the electronic data interchange standards for health care as established by the Secretary of Health and Human Services. The 5010A1 version of the ASC X12 835 Technical Report 3 TR3 has been established as the standard for compliance for the 5010A1 version of the ASC X12 835remittance advice transaction... The formal name of this TR3 is ASC X12 Standards for Electronic Data Interchange Technical Report Type 3—Health Care Claim Payment/Advice (835), and its current HIPAA compliant version is available electronically at the official Washington Publishing Company website.

Although that TR3 or implementation guide contains requirements for use of specific segments and data elements within the segments, it was written for use by all health plans and not specifically for Medicare. However, a Companion Document has been prepared by CMS to clarify when conditional data elements and segments must be used for Medicare reporting when reviewing the Companion Document, keep in mind the following information about loop usage (e.g., required, not used, and situational definitions). For additional information on this subject see the Implementation Guide:

- Loop usage within ASC X12 transactions and their implementation guides can be confusing. Care must be used to read the loop requirements in terms of the context or location within the transaction.

- The usage designator of a loop’s beginning segment indicates the usage of the loop. Segments within a loop cannot be sent without the beginning segment of that loop.

- If the first segment is required, the loop must occur at least once unless it is nested in a loop that is not being used. A note on the required first segment of a nested loop will indicate dependency on the higher-level loop.

- If the first segment is Situational, there will be a Segment Note addressing use of the loop. Any required segments in loops beginning with a Situational segment occur only when the loop is used.

Similarly, nested loops occur only when the higher-level loop is used.

Companion Documents for both Part A and Part B are available at:

http://www.cms.gov/ElectronicBillingEDITrans/30_CcompanionGuides.asp#TopOfPage

60.2 – Claim Adjustment Reason Codes

(Rev. 10236, Issued: 07-31-2020, Effective: 08-31-2020, Implementation: 08-31-2020)

Claim Adjustment Reason Codes (CARCs) are used on the Medicare electronic and paper remittance advice, and Coordination of Benefit (COB) claim transaction. The Claim Adjustment Status and Reason Code Maintenance Committee maintains this code set. A new code may not be added, and the indicated wording may not be modified without the approval of this committee. These codes were developed for use by all U.S. health payers. As a result, they are generic, and there are a number of codes that do not apply to Medicare. This code set is updated three times a year. MACs shall use only most current valid codes in ERA, SPR, and COB claim transactions.

Any reference to procedures or services mentioned in the reason codes apply equally to products, drugs, supplies or equipment. References to prescriptions also include certificates of medical necessity (CMNs).

These reason codes explain the reasons for any financial adjustments, such as denials, reductions or increases in payment. These codes may be used at the service or claim level, as appropriate. Current ASC X12 835 structures only allow one reason code to explain any one specific adjustment amount.

There are basic criteria that the Claim Adjustment Status and Reason Code Maintenance Committee considers when evaluating requests for new claim adjustment reason codes:

- Can the information be conveyed by the use or modification of an existing reason code?
- Is the information available elsewhere in the ASC X12 835?
- Will the addition of the new reason code make any significant difference in the action taken by the provider who receives the message?

The list of Claim Adjustment Reason Codes can be found at the official Washington Publishing Company website.

The updated list is published three times a year after the committee meets before the ASC X12 trimester meeting in the months of January/February, *May*/June, and September/October. MACs must make sure that they are using the latest approved claim adjustment reason codes in ERA, SPR and COB transaction by implementing necessary code changes as instructed in the Recurring Code Update Change Requests (CRs) or any other CMS instruction and/or downloading the list from the WPC website after each update. The Shared System Maintainers shall make sure that a deactivated code (either reason or remark) is not allowed to be used in any original business message, but is allowed and processed when reported in derivative business messages. Code deactivation may be implemented prior to the stop date posted at the WPC web site to follow Medicare release schedule. SSMs shall implement deactivation on the earlier date if the implementation date in the recurring code update CR is different than the stop date posted at the WPC Web site.

The MACs are responsible for entering claim adjustment reason code updates to their shared system and entry of parameters for shared system use to determine how and when particular codes are to be reported in remittance advice and coordination of benefits transactions. In most cases, reason and remark codes reported in remittance advice transactions are mapped to alternate codes used by a shared system. These

shared system codes may exceed the number of the reason and remark codes approved for reporting in a remittance advice transaction. A particular ASC X12 835 reason or remark code might be mapped to one or more shared system codes, or vice versa, making it difficult for a MAC to determine each of the internal codes that may be impacted by remark or reason code modification, retirement, or addition.

Shared systems must provide a crosswalk between the reason and remark codes to the shared system internal codes so that a MAC can easily locate and update each internal code that may be impacted by a remittance advice reason/remark code change to eliminate the need for lengthy and error prone manual MAC searches to identify each affected internal code. Shared systems must also make sure that 5-position remark codes can be accommodated at both the claim and service level for ASC X12 835 version 4010 onwards.

The effective date of programming for use of new or modified reason/remark codes applicable to Medicare is the earlier of the date specified in the CMS manual transmittal or CMS Recurring Code Update change request or the Medicare Claims Processing Manual transmittal that implemented a policy change that led to the issuance of the new or modified code. MACs must notify providers of the new and/or modified codes and their meanings in a provider bulletin or other instructional release prior to issuance of remittance advice transactions that include these changes. Some CARCs are so generic that the reason for adjustment cannot be communicated clearly without at least one remark code. These CARCs have a note added to the text for identification. A/B MACs and DME MACs must use at least one appropriate remark code when using one of these CARCs.

Medicare Claims Processing Manual

Chapter 24 – General EDI and EDI Support Requirements, Electronic Claims, and Mandatory Electronic Filing of Medicare Claims

40.1.1 - HIPAA Transaction Standards as Designated by CMS

(Rev. 10236, Issued: 07-31-2020, Effective: 08-31-2020, Implementation: 08-31-2020)

HIPAA transaction standards shall be supported by the A/B MACs, DME MACs, CEDI or other contractors if designated by CMS for the electronic data with Medicare providers/submitters/receivers/COB trading partners. ASC X12 Technical Report 3s (TR3s) for mandated HIPAA transactions may be purchased from the official Washington Publishing Company website. The HIPAA-standard implementation specifications for claims, remittance advices, and claim status requests follow:

- ASC X12 Standards for Electronic Data Interchange Technical Report Type 3- Health Care Claim: Professional (837)
- ASC X12 Standards for Electronic Data Interchange Technical Report Type 3- Health Care Claim: Institutional (837).
- ASC X12 Standards for Electronic Data Interchange Technical Report Type 3- Health Care Claim Payment/Advice (835).
- ASC X12 Standards for Electronic Data Interchange Technical Report Type 3-Health Care Claim Status Request and Response (276/277). See chapter 31 for additional details.
- Telecommunication Standard Implementation Guide and equivalent Batch Standard Implementation Guide, National Council for Prescription Drug Programs.

Section 10.3 shows the current versions of these standards adopted under HIPAA.

50.2 - Translators

(Rev. 10236, Issued: 07-31-2020, Effective: 08-31-2020, Implementation: 08-31-2020)

A/B MACs and CEDI must accept HIPAA compliant transactions into their front-end system and translate that data into the appropriate flat file format for the transaction type to enable processing by their shared system. HIPAA compliant transactions may include Medicare data (data sent to the core shared system) and non-Medicare data (data not sent to the core shared system). Translators are required to validate the syntax compliance of each inbound transaction against the transaction standards adopted under HIPAA and upon which the implementation guides (also adopted under HIPAA) are based. Syntax edits must be limited to those syntax requirements specified in those implementation guides (IGs) adopted under HIPAA.

A/B MACs and CEDI must use the ASC X12 999 implementation acknowledgment to report transaction level errors detected by translators and to acknowledge receipt of claims that did not contain syntax errors, unless the submitter has indicated a preference not to receive acknowledgments for claims without errors. A/B MACs or CEDI may purge ASC X12 999 implementation acknowledgment transactions from submitter mailboxes after five (5) business days in the event not downloaded by the submitting entity, but are encouraged to retain these as long as 30 days if system capacity permits. Once purged, an A/B MACs or CEDI is not required to be able to recreate that ASC X12 999 implementation acknowledgment transactions. A provider or clearinghouse that failed to download the ASC X12 999 implementation acknowledgment in a

timely manner may submit a claim status query to obtain comparable information for accepted claims. If that response indicates no record of the claim(s), suggesting front end rejection due to a syntax error, the provider/clearinghouse can resubmit the claim and have a new ASC X12 999 implementation acknowledgment issued. The ASC X12 999 implementation acknowledgment TR3 can be downloaded from the official Washington Publishing Company website. A/B MACs and CEDI are required to meet the ASC X12 999 implementation acknowledgment TR3 requirements when issuing the 999.

When receiving claims in the HIPAA adopted NCPDP formats, CEDI must produce a response file in the NCPDP format containing one Transaction Header and one Transaction Trailer with the appropriate syntax error noted in the message field.

A/B MACs and CEDI must accept the entire extended character set. Refer to the ASC X12 TR3 for specifics on the character set. If A/B MACs and CEDI cannot accept more than 9,999 loops or segments per loop in an ASC X12 transaction due to the limitations of their translator, they may reject the transaction at the translator level and use the ASC X12 999 implementation acknowledgment with the IK304 with a value of "4". Translators are to edit the envelope segments (ISA, GS, ST, SE, GE, and IEA) that surround individual transactions so the translation process can immediately reject an interchange, functional group, or transaction set not having met the requirements contained in the specific structure, which could cause software failure when mapping to the flat file. A/B MACs and CEDI are not required to accept multiple functional groups (GS/GE) with multiple transaction types within one transmission for ASC X12 transactions.

For ASC X12 transactions A/B MACs and CEDI translators must also:

- Convert lower case to upper case;
- Pass all spaces to the flat file for fields that are not present in an inbound transaction but which are included in the flat file;
- Map "Not Used" data elements for A/B MACs and CEDI based upon that segment's definition only, i.e., if a data element is never used, do not map it. However, if a data element is "required" or "situational" in some segments but not used in others, then it must be mapped; "Not Used" data elements are not to be mapped to the flat file; and
- Accept multiple interchange envelopes within a single transmission. This is only applicable to ASC X12 transactions as NCPDP only processes a single batch per transmission.
- Translate data for outgoing transactions supplied by the shared system in the flat file format into the appropriate, compliant IG standard as adopted under HIPAA. Translation of outgoing transactions is to follow the same character set and case requirements noted for incoming translation. A/B MACs and CEDI are not required to accept or process ASC X12 999 implementation acknowledgment transactions from trading partners for any outgoing ASC X12 transactions.

See Section 60 for additional A/B MACs and CEDI translator edit requirements that may be specific to individual standards.

60.4 - Remittance Advice and Standard Paper Remittances

(Rev. 10236, Issued: 07-31-2020, Effective: 08-31-2020, Implementation: 08-31-2020)

Remittance advice records shall be provided to explain claim adjudication decisions, including for NCPDP format claims. A/B MACs and CEDI shall send the Electronic Remittance Advice (ERA) in the ASC X12 835 remittance advice format. Or the A/B MACs and DME MACs shall send the remittance as a Standard Paper Remittance (SPR) Advice. HIPAA version implementation guides are available from the official

Washington Publishing Company website. See Chapter 22 of this manual for further remittance advice information.

60.6 - Health Care Provider Taxonomy Code (HPTC) Requirements

(Rev. 10236, Issued: 07-31-2020, Effective: 08-31-2020, Implementation: 08-31-2020)

Health Care Provider Taxonomy Codes (HPTC) are also called Specialty Codes. HPTCs are 9-digit identifiers assigned by the National Uniform Claim Committee (NUCC) to be used in HIPAA transactions.

Contractors are required to validate the incoming HPTC against the most recent taxonomy code list. CMS will notify A/B MACs, their shared system maintainers, and CEDI (via Recurring Update Notification) to load the most recent HPTC code list into a contractor-controlled table. HPTCs may not be hard coded by the shared system maintainers. Contractor-controlled tables minimize the impact of future system updates.

HPTCs are updated twice a year (tentatively October and April) by the NUCC and the updates are available for download in a portable document format (PDF) from the official Washington Publishing Company (WPC) website for no charge or an electronic representation of the list, which could facilitate loading of the codes, may be purchased from WPC on a subscription basis. Contractors are to use the most cost effective means to obtain the list for validation programming and updating purposes.

Medicare Claims Processing Manual
Chapter 31 - ANSI X12 Formats Other than Claims or Remittance

10.2 -Eligibility Connectivity Workflow

(Rev. 10236, Issued: 07-31-2020, Effective: 08-31-2020, Implementation: 08-31-2020)

In 2005, the Centers for Medicare & Medicaid Services (CMS) implemented the *HIPAA Eligibility Transaction System (HETS 270/271)* to address the standards for the Medicare beneficiary eligibility inquiries, creating a centralized ASC X12 270/271 health care eligibility inquiry *application that can process eligibility transactions in real-time.*

For information regarding HETS connectivity, visit the HETS Help web site.

http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/index.html

20 - ASC X12 276/277 Claims Status Request/Response Transaction Standard

(Rev. 10236, Issued: 07-31-2020, Effective: 08-31-2020, Implementation: 08-31-2020)

These instructions apply to Medicare Administrative Contractors (MACs), Durable Medical Equipment Medicare Administrative Contractors (DME MACs), the Common Electronic Data Interchange (CEDI) contractor for DME MACs, and their shared systems on Medicare requirements for their implementation of the current HIPAA compliant version of the ASC X12 Health Care Claim Status Request and Response (276/277) transaction (short reference: ASC X12 276/277 claim status request and response.)

CMS supports the current version of this transaction as established in its TR3 adopted under HIPAA: the ASC X12 Standards for Electronic Data Interchange Technical Report Type 3—Health Care Claim Status Request and Response (276/277).

In order to implement the HIPAA administrative simplification provisions, the ASC X12 276/277 claim status request and response and its implementation specification (now TR3) have been named under part 162 of title 45 of the Code of Federal Regulations as the electronic data interchange (EDI) standard for Health Care Claim Status Request/Response. All other EDI formats for health care claims status request and response became obsolete October 16, 2003. The Final Rule for Health Insurance Reform: Modifications to the Health Insurance Portability and Accountability Act (HIPAA) Electronic Transaction Standards published in the Federal Register on January 16th, 2009, adopts updated versions of the electronic transactions and TR3 for the ASC X12 276/277 claim status request and response. Furthermore, the Final Rule conveys inclusion of errata to the transaction standard. CMS therefore incorporates by reference any errata documents by the original mandated regulation compliance date through the Federal Register notice(s). Moving forward, all newly adopted errata documents are to be accepted and integrated as part of the EDI transaction.

The ASC X12 TR3 for the ASC X12 276/277 claim status request and response standard may be found at the official ASC X12 website. The ASC X12 276/277 is a “paired” transaction (the ASC X12 276 is an in-bound claim status request, and the 277 is an outbound claims status response).

20.7 – Health Care Claim Status Category Codes and Health Care Claim Status Codes for Use with the Health Care Claim Status Request and Response ASC X12 276/277 Claim Status Request and Response

(Rev. 10236, Issued: 07-31-2020, Effective: 08-31-2020, Implementation: 08-31-2020)

Under HIPAA, all payers must use health care claim status category codes and health care claim status codes approved by the Health Care Code Maintenance Committee as applicable. At each ASC X12 trimester

meeting (generally held the months of February, June and October), the Committee may update the claim status category codes and the claim status codes. When instructed, Medicare contractors must update their claims systems to assure that the current version of these codes is used in their claim status responses. The codes sets are available at the official Washington Publishing Company website. Included in the code lists are specific details, including the date when a code was added, changed or deleted.

CMS will issue recurring, one-time change requests regarding the need for and deadline for future updates to these codes. Contractor and shared system changes will be made as necessary as part of a routine release to reflect applicable changes such as retirement of previously used codes or newly created codes that may impact Medicare. Shortly after the release of each code update, a provider education article will be available at http://www.cms.hhs.gov/medlearn/matters for contractors to use to conduct provider outreach.