Medicare Learning Network
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PQRI Information Available

A new CMS webpage dedicated to providing information on the Physician Quality Reporting Initiative (PQRI) is now available.

On December 20, 2006, the President signed the Tax Relief and Health Care Act of 2006 (TRHCA). Section 101 under Title I authorizes the establishment of a physician quality reporting system by CMS. CMS has titled the statutory program the Physician Quality Reporting Initiative. For more information, visit http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html on the CMS website.

Note: This article was updated on June 5, 2013, to reflect current Web addresses. This article was previously revised on March 1, 2007, to reflect changes made to CR5472, which CMS revised on February 28, 2007. The CR transmittal number, release date, and Web address for accessing CR5472 have been revised. All other information remains the same.

MLN Matters Number: MM5472
Related Change Request (CR) #: 5472
Related CR Release Date: February 28, 2007
Effective Date: July 1, 2007
Related CR Transmittal #: R1189CP
Implementation Date: July 2, 2007

Differentiating Mass Adjustments from Other Types of Adjustments and Claims for Crossover Purposes and Revising the Detailed Error Report Special Provider Notification Letters

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Durable Medical Equipment Regional Carriers (DMERCs), DME Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), Part A/B Medicare Administrative Contractors (A/B MACs), and/or Regional Home Health Intermediaries (RHHIs)) for services provided to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You

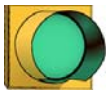
This article is based on Change Request (CR) 5472 which implements changes to Medicare contractor systems so that their claim transmissions to the Coordination of Benefits Contractor (COBC) for mass adjustments and other kinds of adjustments may be differentiated from all other types of claims sent for crossover.

CAUTION – What You Need to Know

This will be accomplished through modifications to the 837 COB flat files and National Council for Prescription Drug Programs (NCPDP) Part B drug claim files, all of which are transmitted to the COBC on a daily basis.

Through CR5472, Medicare contractors' systems will be modified so that the COBC Detailed Error Report information that is printed on the outgoing special provider notification letters/report that you receive when claims will not be crossed over due to claim data errors will be modified to also include the error/trading partner rejection code and accompanying description. These changes to the special provider letters should enable your billing service to determine why claims that were previously selected by Medicare for crossover were not actually crossed over.

Without these changes, CMS would be unable to isolate mass adjustment claims as part of the national COBA crossover process. This change corrects a problem that the Centers for Medicare & Medicaid Services (CMS) encountered as part of its implementation of the Deficit Reduction Act (DRA). Also, providers would continue to be unaware of the specific reasons as to why their patients' claims were not crossed over.



GO – What You Need to Do

See the Background and Additional Information Sections of this article for further details regarding these changes.

Background

All Medicare contractors currently send processed claims, for which Medicare systems show the beneficiary has other insurance to the COBC for crossover under the national Coordination of Benefits Agreement (COBA) program.

The Centers for Medicare & Medicaid Services (CMS) requires a method whereby its Coordination of Benefits Contractor (COBC) can differentiate among the various categories of adjustment crossover claims including:

- Mass adjustments - Medicare physician fee schedule (MPFS),
- Mass adjustments - other, and
- All other adjustments.

Having the ability to differentiate among the various categories of adjustment crossover claims will enable CMS (and the COBC) to better address the kinds of contingencies that arise with the passage of legislation such as the Deficit Reduction Act, which mandate changes for Medicare that can affect claims already processed.

CR5472 instructs that the COBC Detailed Error Report process be modified to ensure that the contractor-generated special provider letters which are created and sent in accordance with CR 3709 contain the specific Claredi rejection code returned for the claim along with its description. (See the MLN Matters article at http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM3709.pdf for information on CR3709.)

Providers may wish to contact their billing agent/vendor to obtain a better understanding of these error codes and accompanying descriptions, which, in turn, explains why their patients' claims were not crossed over successfully. In addition, providers should notify their billing agent/vendor when they receive special provider letters or reports stating why their patients' claims were not crossed over.

Additional Information

The official instruction, CR5472, issued to your carrier, FI, RHHI, A/B MAC, DMERC, or DME MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1189CP.pdf on the CMS website. Attached to CR5472, you will find the new chapter of the *Medicare Claims Processing Manual* explaining in detail the new special mass adjustment process for COB. In addition, you will also find revised chapters for other portions of that manual, which discuss the COB process.

If you have any questions, please contact your carrier, FI, RHHI, A/B MAC, DMERC, or DME MAC at their toll-free number, which may be found on the CMS website at: http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.

Flu Shot Reminder

It's Not Too Late to Give and Get the Flu Shot

The peak of flu season typically occurs between late December and March; however, flu season can last until May. Protect yourself, your patients, and your family and friends by getting and giving the flu shot. Each office visit presents an opportunity for you to talk with your patients about the importance of getting an annual flu shot and a lifetime pneumococcal vaccination. Remember - influenza and pneumococcal vaccination and their administration are covered Part B benefits. Note that influenza and pneumococcal vaccines are NOT Part D covered drugs. For more information about Medicare's coverage of adult immunizations and educational resources, go to CMS' website: http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/SE0667.pdf.