CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 4047	**Date: May 11, 2018**
	Change Request 10619

SUBJECT: Updates to Publication 100-04, Chapters 1 and 27 to Replace Remittance Advice Remark Code (RARC) MA61 with N382

I. SUMMARY OF CHANGES: This Change Request initiates both manual changes and operational changes related to the New Medicare Card Project. RARC MA61, within Pub 100-04, Chapters 1 and 27, is being replaced with RARC N382 and Medicare Administrative Contractors shall use N382 in place of MA61 to communicate reject/denials for patient identifiers (HICN or MBI) in all remittance advices and 835 transactions.

EFFECTIVE DATE: August 13, 2018 - Effective Date is Process Date
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: August 13, 2018

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	1/80/80.3.2.1.1/A/B MAC (B) Data Element Requirements
R	27/20/20.3.3.4/Disposition Code 53 (Record in CMS Alpha Match)
R	27/20/20.3.3.6/Disposition Code 55 (Personal Characteristic Mismatch)

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: 4047	Date: May 11, 2018	Change Request: 10619

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I. GENERAL INFORMATION

A. Background: With the implementation of the Medicare Beneficiary Identifier (MBI), references to the Health Insurance Claim Number (HICN) need to be removed and replaced with a more generic reference (Patient Identifier). This Change Request initiates the manual changes and operational changes to accomplish this task.

B. Policy: Not Applicable

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	
10619.1	Contractors shall make the necessary system changes to use RARC N382 instead of RARC MA61 when communicating rejections/denials related to a missing/incomplete/invalid patient identifier (HICN or MBI).	X	X	X	X					
10619.2	Contractors shall use RARC MA61 only when/if communicating rejections/denials related to a missing/incomplete/invalid social security number.	X	X	X	X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility		
		A/B MAC	DME	CED

		A	B	H H H	M A C	I
10619.3	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 5 business days after receipt of the notification from CMS announcing the availability of the 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	

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: N/A

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

V. CONTACTS

Pre-Implementation Contact(s): Carla Douglas, 410-786-4799 or carla.douglas@cms.hhs.gov , Brian Reitz, 410-786-5001 or brian.reitz@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

80.3.2.1.1 - A/B MAC (B) Data Element Requirements

(Rev.4047, Issued: 05 - 11- 18, Effective: 08-13-18, Implementation: 08 - 13-18)

A - Required Data Element Requirements

1 - Paper Claims

The following instruction describes certain data element formatting requirements to be followed when reporting the calendar year date for the identified items on the Form CMS-1500:

- If birth dates are furnished in the items stipulated below, then these items must contain 8-digit birth dates (MMDDCCYY). This includes 2-digit months (MM) and days (DD), and 4-digit years (CCYY).

Form CMS-1500 Items Affected by These Reporting Requirements:

Item 3 - Patient's Birth Date

Item 9b - Other Insured's Date of Birth

Item 11a - Insured's Date of Birth

Note that 8-digit birth dates, when provided, must be reported with a space between month, day, and year (i.e., MM_DD_CCYY). On the Form CMS-1500, the space between month, day, and year is delineated by a dotted, vertical line.

If a birth date is provided in items 3, 9b, or 11a, and is not in 8-digit format, carriers must return the claim as unprocessable.

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 Two.

Group Code: CO
CARC: 16
RARC: N329
MSN: N/A

If carriers do not currently edit for birth date items because they obtain the information from other sources, they are not required to return these claims if a birth date is reported in items 3, 9b, or 11a. and the birth date is not in 8-digit format. However, if carriers use date of birth information on the incoming claim for processing, they must edit and return claims that contain birth date(s) in any of these items that are not in 8-digit format.

For certain other Form CMS-1500 conditional or required date items (items 11b, 14, 16, 18, 19, or 24A.), when dates are provided, either a 6-digit date or 8-digit date may be provided.

If 8-digit dates are furnished for any of items 11a., 14, 16, 18, 19, or 24A. (excluding items 12 and 31), carriers must note the following:

- All completed date items, except item 24A., must be reported with a space between month, day, and year (i.e., MM_DD_CCYY). On the Form CMS-1500, the space between month, day, and year is delineated by a dotted, vertical line;

- Item 24A. must be reported as one continuous number (i.e., MMDDCCYY), without any spaces between month, day, and year. By entering a continuous number, the date(s) in item 24A. will penetrate the dotted, vertical lines used to separate month, day, and year. Carrier claims processing systems will be able to process the claim if the date penetrates these vertical lines. However, all 8-digit dates reported must stay within the confines of item 24A;

- Do not compress or change the font of the "year" item in item 24A. to keep the date within the confines of item 24A. If a continuous number is furnished in item 24A. with no spaces between month, day, and year, you will not need to compress the "year" item to remain within the confines of item 24A.;

- The "from" date in item 24A. must not run into the "to" date item, and the "to" date must not run into item 24B.;

- Dates reported in item 24A. must not be reported with a slash between month, day, and year; and

- If the provider of service or supplier decides to enter 8-digit dates for any of items 11b, 14, 16, 18, 19, or 24A. (excluding items 12 and 31), an 8-digit date must be furnished for all completed items. For instance, you cannot enter 8-digit dates for items 11b, 14, 16, 18, 19 (excluding items 12 or 31), and a 6-digit date for item 24A. The same applies to those who wish to submit 6-digit dates for any of these items.

A/B MACs (B) must return claims as unprocessable if they do not adhere to these requirements.

2 - Electronic Claims

A/B MACs (B) must return all electronic claims that do not include an 8-digit birth date (CCYYMMDD) when a date is reported.

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 Two.

Group Code: CO
CARC: 16
RARC: N329
MSN: N/A

If A/B MACs (B) do not currently edit for birth date items because they obtain the information from other sources, they are not required to return these claims if a birth date is reported in items 3, 9b., or 11a. and the birth date is not in 8-digit format. However, if A/B MACs (B) do use date of birth information on the incoming claim for processing, they must edit and return claims that contain birth date(s) in any of these items that are not in 8-digit format.

B - Required Data Element Requirements

The following Medicare-specific, return as unprocessable requirements in this section and the following two sections are in addition to requirements established under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Regulations implementing HIPAA require the use of National Provider Identifiers (NPIs) by covered health care providers and health plans. Although not required by HIPAA, CMS is extending the requirement to include the NPI on electronic claims to paper claims submitted on the Form CMS-1500. A/B MACs (B) are referred to the Health Care Claims Professional 837 Implementation guide for requirements for professional claims subject to HIPAA, including the NPI reporting requirements.

A/B MACs (B) must return a claim as unprocessable to a provider of service or supplier and use the indicated remittance advice codes.

Carriers shall return a claim as unprocessable:

1. If a claim lacks a valid Medicare Health Insurance Claim Number (HICN) in item 1a. or contains an invalid HICN in item 1a.

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 Two.

Group Code: CO
CARC: 16
RARC: *N382*
MSN: N/A

20.3.3.4 - Disposition Code 53 (Record in CMS Alpha Match)

(Rev.4047, Issued: 05 - 11- 18, Effective: 08-13-18, Implementation: 08 - 13-18)

- If CMS sends a claim to alpha search, it must send a disposition code 53 to the Host. The Host puts a code 53 on its TNIF file.

- The Satellite receives code 53 and Trailer 08 with a 5052 error code on the next recycle of the claim.

- The Satellite must recycle the claim 15 working days after receiving this code.

- If an AAR response is not received after the receipt of the third code 53 for the same claim, the Satellite must deny the claim using the following messages:

  MSN message 5.1: "Our records show that you do not have Medicare entitlement under the number shown on this notice. If you do not agree, please contact your local Social Security office."

  Group Code CO, Claim Adjustment Reason Code (CARC) 16 (Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present), and Remittance Advice Remark Code (RARC) *N382 - Missing/incomplete/invalid patient identifier.*

20.3.3.6 - Disposition Code 55 (Personal Characteristic Mismatch)

(Rev.4047, Issued: 05 - 11- 18, Effective: 08-13-18, Implementation: 08 - 13-18)

The Host provides the Satellite with this disposition code and Trailer 08 with error code 5052 when it discovers a mismatch of the Health Insurance Claim Number (HICN) with the beneficiary's personal characteristics such as name, sex or date of birth.

If CWF rejects a claim and sends back disposition code 55 with the 08 trailer containing Error Code 5052 when the beneficiary's personal characteristics do not match the HICN in accordance with the CWF matching criterion, contractors shall return the claim to the provider as unprocessable with the identifying beneficiary information from the submitted claim as follows:

A/B MACs (A, HHH) shall return to provider (RTP) Part A claims. These A/B MACs shall not mail an MSN for these claims.

A/B MACs (B) and DME MACs shall return as unprocessable Part B provider submitted claims. The A/B MACs (B) and DME MACs shall not mail an MSN for these claims. When returning these claims as unprocessable, the shared processing system shall use Claim Adjustment Group Code (Group Code) CO – Contractual Obligation, Claim Adjustment Reason Code (CARC) 16 - Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice

Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present with Remittance Advice Remark Codes (RARCs) MA27 - Missing/incomplete/invalid entitlement number or name shown on the claim and *N382 - Missing/incomplete/invalid patient identifier.*

For assigned and non-assigned Part B claims submitted by the beneficiary on the Form CMS-1490S or Form CMS-1500, A/B MACs (B) and DME MACs shall manually return the claim in accordance with Pub.100-04, Chapter 1, Section 80.3.2 A. "Special Considerations."