CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 4201	**Date: January 18, 2019**
	Change Request 10916

SUBJECT: Update to Pub. 100-04 Chapter 1 to Provide Language-Only Changes for the New Medicare Card Project

I. SUMMARY OF CHANGES: This CR contains language-only changes for updating the New Medicare Card Project-related language in Pub 100-04, Chapter 1. There are no new coverage policies, payment policies, or codes introduced in this transmittal. Specific policy changes and related business requirements have been announced previously in various communications.

EFFECTIVE DATE: February 19, 2019
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: February 19, 2019

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	1/10.5/Claims Processing Requirements for Deported Beneficiaries
R	1/10.5.1/Implementation of Payment Policy for Deported Medicare Beneficiaries
R	1/30.3.5/Effect of Assignment Upon Purchase of Cataract Glasses From Participating Physician or Supplier on Claims Submitted to Carriers
R	1/50.1.2/Beneficiary Request for Payment on Provider Record - ASC X12 837 Institutional Claims
R	1/70.2.3.1/ Incomplete or Invalid Submissions
R	1/70.2.3.2/Handling Incomplete or Invalid Submissions
R	1/80.3.2/Handling Incomplete or Invalid Claims
R	1/80.3.2.1.1/A/B MAC (B) Data Element Requirements
R	1/80.3.3/Timeliness Standards for Processing Other-Than-Clean Claims
R	1/80.4/Enforcement of Provider Billing Timelines and Accuracy Standard to Continue PIP (Periodic Interim Payment)
R	1/120.2/Exact Duplicates
R	1/130.1/General Rules for Submitting Adjustment Requests
R	1/130.1.2.1/Claim Change Reason Codes
R	1/130.1.3/Late Charges
R	1/130.2/Inpatient Part A Hospital Adjustment Bills
R	1/130.3.1/Tolerance Guides for Submitting SNF Inpatient Adjustment Requests
R	1/130.5.1/Submitting Adjustment Requests
R	1/130.6/Adjustments to Reprocess Certain Claims Denied Due to an Open Common Working File (CWF) Medicare Secondary Payer (MSP) Group Health Plan (GHP) Record Where the GHP Record Was Subsequently Deleted or Terminated

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: 4201	Date: January 18, 2019	Change Request: 10916

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EFFECTIVE DATE: February 19, 2019
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I. GENERAL INFORMATION

A. Background: The Centers for Medicare & Medicaid Services (CMS) is implementing changes to remove the Social Security Number (SSN) from the Medicare card. A new number, called the Medicare Beneficiary Identifier (MBI), will be assigned to all Medicare beneficiaries. This CR contains language-only changes for updating the New Medicare Card Project language related to the MBI in Pub 100-04, Chapter 1.

B. Policy: The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires removal of the Social Security Number (SSN)-based Health Insurance Claim Number (HICN) from Medicare cards within four years of enactment. There are no new coverage policies, payment policies, or codes introduced in this transmittal. Specific policy changes and related business requirements have been announced previously in various communications.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
10916.1	MACs shall be aware of the updated language for the New Medicare Card Project in Pub. 100 - 04, Chapter 1.	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
	None					

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): Tracey Mackey, 410-786-5736 or Tracey.Mackey@cms.hhs.gov , Kimberly Davis, 410-786-4721 or kimberly.davis@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

10.5 - Claims Processing Requirements for Deported Beneficiaries
(Rev. 4201, Issued: 01-18-19, Effective: 02-19-19, Implementation: 02-19-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

Section 202(n) of the Social Security Act (the Act), requires the termination of Title II benefits upon deportation. Moreover, Sections 226 and 226(A) of the Act provide that no payments may be made for benefits under Part A of Title XVIII of the Act if there is no monthly benefit payable under Title II. Section 1836 of the Act limits Part B benefits to those who are either entitled to Part A benefits or who are age 65 and a United States (U.S.) resident, U.S. citizen, or a lawfully admitted alien residing permanently in the U.S. Given that, a deported beneficiary is not allowed to enter the U.S. and cannot be lawfully present in the United States to receive Medicare-covered services, Medicare payment cannot be made for Part B Benefits.

An audit of Medicare payments by the Office of Inspector General identified a vulnerability for the Medicare trust fund with respect to this issue. The study identified improper payments for beneficiaries, who, on the date of service on the claim, had been deported. To address this vulnerability, CMS is establishing claim level editing using data from the Social Security Administration (SSA). Specifically, the data contains the name and *Medicare beneficiary identifier* of the Medicare beneficiary and the month the deportation is effective. CWF will reject claims where the effective date on the Master Beneficiary Record is equal to or greater than the date of service on the claim. All claims rejected by CWF shall be denied by the respective *A/B MAC (B), DME MAC, A/B MAC (HHH)* or *A/B MAC (A)* that submitted the claim to CWF.

Policy:

Medicare payment shall not be made for an item or service furnished to an individual that has been deported from the United States.

Appeals:
A party to a claim denied in whole or in part under this policy may appeal the initial determination on the basis of the deportation status at the time the item or service was furnished.

10.5.1 - Implementation of Payment Policy for Deported Medicare Beneficiaries
(Rev. 4201, Issued: 01-18-19, Effective: 02-19-19, Implementation: 02-19-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

A. CWF Editing of Claims

1. An auxiliary file shall be established in the Common Working File to contain deportation status.

2. This auxiliary file will be the basis for an edit that rejects claims submitted by Medicare contractors.

3. The edit will reject a claim where the *Medicare beneficiary identifier* on the claim matches the *Medicare beneficiary identifier* on the Master Beneficiary Record and the date of service is on or after the date of deportation.

B. Contractors Actions

Medicare contractors shall deny claims for items and services when rejected by CWF. The contractor shall refer to the CWF documentation on this subject for the error code assigned to this editing. All denials will provide appeal rights as specified in section 10.5.

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 Three.

Group Code: PR
CARC: 96
RARC: N126
MSN: 16.56

30.3.5 - Effect of Assignment Upon Purchase of Cataract Glasses From Participating Physician or Supplier on Claims Submitted to Carriers

(Rev. 4201, Issued: 01-18-19, Effective: 02-19-19, Implementation: 02-19-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

A pair of cataract glasses is comprised of two distinct products: a professional product (the prescribed lenses) and a retail commercial product (the frames). The frames serve not only as a holder of lenses but also as an article of personal apparel. As such, they are usually selected on the basis of personal taste and style. Although Medicare will pay only for standard frames, most patients want deluxe frames. Participating physicians and suppliers cannot profitably furnish such deluxe frames unless they can make an extra (noncovered) charge for the frames even though they accept assignment.

Therefore, a participating physician or supplier (whether an ophthalmologist, optometrist, or optician) who accepts assignment on cataract glasses with deluxe frames may charge the Medicare patient the difference between his/her usual charge to private pay patients for glasses with standard frames and his/her usual charge to such patients for glasses with deluxe frames, in addition to the applicable deductible and coinsurance on glasses with standard frames, if all of the following requirements are met:

A. The participating physician or supplier has standard frames available, offers them for sale to the patient, and issues and ABN to the patient that explains the price and other differences between standard and deluxe frames. Refer to Chapter 30.

B. The participating physician or supplier obtains from the patient (or his/her representative) and keeps on file the following signed and dated statement:

_____

Name of Patient *Medicare beneficiary identifier*

Having been informed that an extra charge is being made by the physician or supplier for deluxe frames, that this extra charge is not covered by Medicare, and that standard frames are available for purchase from the physician or supplier at no extra charge, I have chosen to purchase deluxe frames.

_____

Signature Date

C. The participating physician or supplier itemizes on his/her claim his/her actual charge for the lenses, his/her actual charge for the standard frames, and his/her actual extra charge for the deluxe frames (charge differential).

Once the assigned claim for deluxe frames has been processed, the carrier will follow the ABN instructions as described in §60.

50.1.2 - Beneficiary Request for Payment on Provider Record - ASC X12 837 Institutional Claims

(Rev. 4201, Issued: 01-18-19, Effective: 02-19-19, Implementation: 02-19-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

A participating provider (hospital, critical access hospital, skilled nursing facility, home health agency, outpatient physical therapy provider, or comprehensive outpatient rehabilitation facility), ESRD facility, Independent rural health clinic, freestanding Federally Qualified Health Clinic, Religious Nonmedical Health Care Institution, or Community Mental Health Centers must use a procedure under which the signature of the patient (or his representative) on its records will serve as a request for payment for services of the provider.

To implement this procedure the provider must incorporate language to the following effect in its records:

Request for Payment

_____ _____

NAME OF BENEFICIARY *Medicare beneficiary identifier*

I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by or in (name of provider). I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

For services furnished to inpatients of a hospital, or SNF, the request is effective for the period of confinement. For services furnished by an HHA under a plan of treatment the request is effective for the plan of treatment. For other services the request is effective until revoked. If a patient objects to part of the request for payment, the provider should annotate the statement accordingly.

In using this procedure, the provider undertakes to make the patient signature files available for A/B MAC (A and B) inspection on request.

The A/B MAC (A and B) must make periodic audits of signature files selected on a random basis. The A/B MAC (B) may arrange with the A/B MAC (A) for the latter to perform this function on its behalf for A/B MAC (B) claims submitted by providers.

70.2.3.1 - Incomplete or Invalid Submissions

(Rev. 4201, Issued: 01-18-19, Effective: 02-19-19, Implementation: 02-19-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

Services not submitted in accordance with CMS instructions include:

- Incomplete Submissions - Any submissions missing required information (e.g., no provider name).
- Invalid submissions - Any submissions that contains complete and required information; however, the information is illogical or incorrect (e.g., incorrect *Medicare beneficiary identifier*, invalid procedure codes) or does not conform to required claim formats.

The following definitions may be applied to determine whether submissions are incomplete or invalid:

- Required - Any data element that is needed in order to process the submission (e.g., Provider Name).
- Not Required - Any data element that is optional or is not needed in order to process the submission (e.g., Patient's Marital Status).
- Conditional - Any data element that must be completed if other conditions exist (e.g. if there is insurance primary to Medicare, then the primary insurer's group name and number must be entered on a claim). If these conditions exist, the data element becomes required.

Submissions that are found to be incomplete or invalid are returned to the provider (RTP). The incomplete or invalid information is detected by the FI's claims processing system. The electronic submission is returned to the provider of service electronically, with notation explaining the error(s). Assistance for making corrections is available in the on-line processing system (Direct Data Entry) or through the FI. In the limited cases where paper submission are applicable, paper submissions found to be incomplete or invalid prior to or during entry into the contractor's claims processing system are returned to the provider of service by mail, with an attached form explaining the error(s).

The electronic records of claims that are RTP are held in a temporary storage location in the FI's claims processing system. The records are held in this location for a period of time that may vary among FIs, typically 60 days or less. During this period, the provider may access the electronic record and correct it, enabling the submission to be processed by the FI. If the incomplete or invalid information is not corrected within the temporary storage period, the electronic record is purged by the FI. There is no subsequent audit trail or other record of the submission being received by Medicare. These submissions are never reflected on a RA. No permanent record is kept of the submissions because they are not considered claims under Medicare regulation.

70.2.3.2 - Handling Incomplete or Invalid Submissions

(Rev. 4201, Issued: 01-18-19, Effective: 02-19-19, Implementation: 02-19-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the

Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

The A/B MACs (A) should take the following actions upon receipt of incomplete or invalid submissions:

- If a required data element is not accurately entered in the appropriate field, RTP the submission to the provider of service.

- If a not required data element is accurately or inaccurately entered in the appropriate field, but the required data elements are entered accurately and appropriately, process the submission.

- If a conditional data element (a data element which is required when certain conditions exist) is not accurately entered in the appropriate field, RTP the submission to the provider of service.

- If a submission is RTP for incomplete or invalid information, at a minimum, notify the provider of service of the following information:

    - Beneficiary's Name;
    - *Medicare beneficiary identifier*;
    - Statement Covers Period (From-Through);
    - Patient Control Number (only if submitted);
    - Medical Record Number (only if submitted); and
    - Explanation of Errors.

NOTE: Some of the information listed above may in fact be the information missing from the submission. If this occurs, the A/B MAC (A) includes what is available.

- If a submission is RTP for incomplete or invalid information, the A/B MAC (A) shall not report the submission on the MSN to the beneficiary. The notice must only be given to the provider or supplier.

Refer to the implementation guide for the current ASC X12 837 institutional claim format for specifications. If a claim fails edits for any one of the content or size requirements, the A/B MAC (A) will RTP the submission to the provider of service.

NOTE: The data element requirements in the implementation guide may be superseded by subsequent CMS instructions. The CMS is continuously revising instructions to accommodate new data element requirements.

The A/B MACs (A) must provide a listing of the required data elements, including a brief explanation to providers and suppliers. A/B MACs (A) must educate providers regarding the distinction between submissions which are not considered claims, but which are returned to provider (RTP) and submissions which are accepted by Medicare as claims for processing but are not paid. Claims may be accepted as filed by Medicare systems but may be rejected or denied. Unlike RTPs, rejections and denials are reflected on RAs. Denials are subject to appeal, since a denial is a payment determination. Rejections may be corrected and re-submitted.

80.3.2 - Handling Incomplete or Invalid Claims

(Rev. 4201, Issued: 01-18-19, Effective: 02-19-19, Implementation: 02-19-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

Claims processing specifications describe whether a data element is required, not required, or conditional (a data element which is required when certain conditions exist). The status of these data elements will affect whether or not an incomplete or invalid claim (hardcopy or electronic) will be "returned as unprocessable" by the A/B MAC (B) or “returned to provider” (RTP) by the A/B MAC (A). The contractor shall not deny claims and afford appeal rights for incomplete or invalid information as specified in this instruction. (See §80.3.1 for Definitions.)

If a data element is required and it is not accurately entered in the appropriate field, the contractor returns the claim to the provider of service.

- If a data element is required, or is conditional (a data element that is required when certain conditions exist) and the conditions of use apply) and is missing or not accurately entered in its appropriate field, the contractor shall return as unprocessable or RTP the claim to either the supplier or provider of service.

NOTE: Effective for claims with dates of service (DOS) on or after the implementation date of the ordering and referring phase 2 edits, Part B clinical lab and imaging technical or global component claims, Durable Medical Equipment, Prosthetics, claims and Home Health Agency (HHA) claims shall be denied, in accordance with CMS-6010-F final rule published on April 24, 2012, if the ordering or referring provider’s information is invalid or if the provider is not of a specialty that is eligible to order and refer.

- If a claim must be returned as unprocessable or RTP for incomplete or invalid information, the contractor shall, at minimum, notify the provider of service of the following information:
    - Beneficiary’s Name;
    - *Medicare beneficiary identifier*;
    - Dates of Service (MMDDCCYY) (Eight-digit date format effective as of October 1, 1998);
    - Patient Account or Control Number (only if submitted);
    - Medical Record Number (FIs only, if submitted); and
    - Explanation of Errors (e.g., Remittance Advice Reason and Remark Codes)

NOTE: Some of the information listed above may in fact be the information missing from the claim. If this occurs, the contractor includes what is available.

Depending upon the means of return of a claim, the supplier or provider of service has various options for correcting claims returned as unprocessable or RTP for incomplete or invalid information. They may submit corrections either in writing, on-line, or via telephone when the claim was suspended for development, or submit as a “corrected” claim or as an entirely new claim if data from the original claim was not retained in the system, as with a front-end return, or if a remittance advice was used to return the claim. The chosen mode of submission, however, must be currently supported and appropriate with the action taken on the claim.

NOTE: The supplier or provider of service must not be denied any services (e.g., modes of submission or customer service), other than a review, to which they would ordinarily have access.

- If a claim or a portion of a claim is “returned as unprocessable” or RTP for incomplete or invalid information, the contractor does not generate an MSN to the beneficiary.

- The notice to the provider or supplier will not contain the usual reconsideration notice, but will show each applicable error code or equivalent message.

- If the contractor uses an electronic or paper remittance advice notice to return an unprocessable claim, or a portion of unprocessable claim:

1. The remittance advice must demonstrate all applicable error codes. At a minimum there must be a CARC/RARC combination that is compliant with CAQH CORE Business Scenario Two.

2. The returned claim or portion must be stored and annotated, as such, in history, if applicable. If contractors choose to suspend and develop claims, a mechanism must be in place where the contractor can re-activate the claim or portion for final adjudication.

A. Special Considerations

- If a "suspense" system is used for incomplete or invalid claims, the contractor will not deny the claim with appeal rights if corrections are not received within the suspense period, or if corrections are inaccurate. The contractor must return the unprocessable claim, without offering appeal rights, to the provider of service or supplier.

For assigned and unassigned claims submitted by beneficiaries (Form CMS-1490S), that are incomplete or contain invalid information, contractors shall manually return the claims to the beneficiaries. If the beneficiary furnishes all other information but fails to supply the provider or supplier's NPI, and the contractor can determine the NPI using the NPI registry, the contractor shall continue to process and adjudicate the claim. If the contractor determines that the provider or supplier was not a Medicare enrolled provider with a valid NPI, the contractor shall follow previously established procedures in order to process and adjudicate the claim.

Contractors shall send a letter to the beneficiary with information explaining which information is missing, incorrect or invalid; information explaining the mandatory claims filing requirements; instructions for resubmitting the claim if the provider or supplier refuses to file the claim, or enroll in Medicare, and shall include language encouraging the beneficiary to seek non-emergency care from a provider or supplier that is enrolled in the Medicare program. Contractors shall also notify the provider or supplier about his/her obligation to submit claims on behalf of Medicare beneficiaries and that providers and suppliers are required to enroll in the Medicare program to receive reimbursement.

Contractors shall consider a complete claim to have all items on the Form CMS-1490S completed along with an itemized bill with the following information: date of service, place of service, description of each surgical or medical service or supply furnished; charge for each service; treating doctor's or supplier's name and address; diagnosis code; procedure code and the provider or supplier's NPI. Required information on a claim must be valid for the claim to be considered as complete.

If a beneficiary submits a claim on the Form CMS-1500, return the Form CMS-1500 claim to the beneficiary, and include a copy of the Form CMS-1490S, along with a letter instructing the beneficiary to complete and return the Form CMS-1490S for processing within the time period prescribed in §70.5 above. Include in the letter a description of missing, invalid or incomplete items required for the Form CMS-1490S that were not included with the submitted Form CMS-1500 or were invalid.

NOTE: Telephone inquiries are encouraged.

- Contractors shall not return an unprocessable claim if the appropriate information for both "required" and "conditional" data element requirements other than an NPI when the NPI is effective is missing or inaccurate but can be supplied through internal files. Contractors shall not search their internal files to correct missing or inaccurate "required" and "conditional" data elements required under

Sections 80.3.2.1.1 through 80.3.2.1.3 and required for HIPAA compliance for claims governed by HIPAA.

- For either a paper or electronic claim, if all "required" and "conditional" claim level information that applies is complete and entered accurately, but there are both "clean" and "dirty" service line items, then split the claim and process the "clean" service line item(s) to payment and return as unprocessable the "dirty" service line item(s) to the provider of service or supplier**. NOTE:** This requirement applies to carriers only.

No workload count will be granted for the "dirty" service line portion of the claim returned as unprocessable. The "clean" service line portion of the claim may be counted as workload **only if it is processed through the remittance process**. Contractors must abide by the specifications written in the above instruction; return the "dirty" service line portion without offering appeal rights.

- Workload will be counted for claims returned as unprocessable through the remittance process. Under no circumstances should claims returned as unprocessable by means other than the remittance process (e.g., claims returned in the front-end) be reported in the workload reports submitted to CMS. The contractor is also prohibited from moving or changing the action on an edit that will result in an unprocessable claim being returned through the remittance process. If the current action on an edit is to suspend and develop, reject in the front or back-end, or return in the mailroom, the contractor must continue to do so. Workload is only being granted to accommodate those who have edits which currently result in a denial. As a result, workload reports should not deviate significantly from those reports prior to this instruction.

NOTE: Rejected claims are not counted as an appeal on resubmissions.

B. Special Reporting of Unprocessable Claims Rejected through the Remittance Process (Carriers Only):

A/B MACs (B) must report "claims returned as unprocessable on a remittance advice" on line 15 (Total Claims Processed) and on line 14 (subcategory Non-CWF Claims Denied) of page one of your Form CMS-1565. Although these claims are technically not denials, line 14 is the only suitable place to report them given the other alternatives. In addition, these claims should be reported as processed "not paid other" claims on the appropriate pages (pages 2-9) of CROWD Form T for the reporting month in which the claims were returned as unprocessable through the remittance process. Also, A/B MACs (B) report such claims on Form Y of the Contractor Reporting of Operational and Workload Data (CROWD) system. They report the "number of such claims returned during the month as unprocessable through the remittance process" under Column 1 of Form Y on a line using code "0003" as the identifier.

If a supplier, physician, or other practitioner chooses to provide missing or invalid information for a suspended claim by means of a telephone call or in writing (instead of submitting a new or corrected claim), A/B MACs (B) do not report this activity as a claim processed on Form CMS-1565/1566. Instead, they subtract one claim count from line 3 of Form Y for the month in which this activity occurred.

EXAMPLE: Assume in the month of October 2001 the carrier returned to providers 100 claims as unprocessable on remittance advices. The carrier should have included these 100 claims in lines 14 and 15 of page 1 of your October 2001 Form CMS-1565. During this same month, assume the carrier received new or corrected claims for 80 of the 100 claims returned during the month. These 80 claims should have been counted as claims received in line 4 of your October 2001 Form CMS-1565 page one (and subsequently as processed claims for the reporting month when final determination was made).

Also, during October 2001, in lieu of a corrected claim from providers, assume the carrier received missing information by means of a telephone call or in writing for 5 out of the 100 claims returned during October 2001. This activity should not have been reported as new claims received (or subsequently as claims processed when adjustments are made) on Form CMS-1565. On line 3 of Form Y for October 2001, the

A/B MAC (B) should have reported the number 95 (From claims returned as unprocessable through the remittance process minus 5 claims for which the carrier received missing or invalid information by means of a telephone call or in writing.

For the remaining 15 claims returned during October 2001 with no response from providers in that same month, the carrier should have reported on the Form CMS-1565 or Form Y, as appropriate, any subsequent activity in the reporting month that it occurred. For any of these returned claims submitted as new or corrected claims, the A/B MAC (B) should have reported their number as receipts on line 4 of page one of Form CMS-1565. For any of these returned claims where the supplier or provider of service chose to supply missing or invalid information by means of a telephone call or in writing, the A/B MAC (B) should not have counted them again on Form CMS-1565, but subtracted them from the count of returned claims reported on line 3 of Form Y for the month this activity occurred.

C. Exceptions (A/B MACs (B) Only)

The following lists some exceptions when a claim may not be "returned as unprocessable" for incomplete or invalid information.

A/B MACs (B) shall not return a claim as unprocessable:

If a patient, individual, physician, supplier, or authorized person's signature is missing, but the signature is on file, or if the applicable signature requirements have been met, do not return a claim as unprocessable where an authorization is attached to the claim or if the signature field has any of the following statements (unless an appropriate validity edit fails):

Acceptable Statements for Form CMS-1500:

- For items 12, 13, and 31, "Signature on File" statement and/or a computer generated signature;
- For items 12 and 13, Beneficiary's Name "By" Representative's Signature;

For item 12, "X" with a witnessed name and address. (Chapter 26 for instructions.)

D. Misdirected Claims

See §10.1.9 for instructions on handling claims that are submitted to the wrong contractor, or to the wrong payment jurisdiction.

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

(Rev. 4201, Issued: 01-18-19, Effective: 02-19-19, Implementation: 02-19-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

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 beneficiary identifier* in item 1a. or contains an invalid *Medicare beneficiary identifier* 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

80.3.3 - Timeliness Standards for Processing Other-Than-Clean Claims

(Rev. 4201, Issued: 01-18-19, Effective: 02-19-19, Implementation: 02-19-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

The Social Security Act, at §1869(a)(2), mandates that Medicare process all "other-than-clean" claims and notify the individual filing such claims of the determination within 45 days of receiving such claims.

Claims that do not meet the definition of "clean" claims are "other-than-clean" claims. "Other-than-clean" claims require investigation or development external to the contractor's Medicare operation on a prepayment basis.

The contractor shall process all "other-than-clean" claims and notify the provider and provider of the determination within 45 calendar days of receipt. (See Pub100-4, Chapter 1, §80.2.1 for the definition of "receipt date" and for timeliness standards for clean claims.) However, when the contractor develops to the provider/supplier or beneficiary for additional information, the contractor shall cease counting the 45 calendar days on the day that the contractor sends the development letter. Upon receiving the materials requested in the development letter from the provider/supplier and/or beneficiary, the contractor shall resume counting the 45 calendar days.

EXAMPLE:

The contractor receives a claim on June 1st, but does not send a development letter to the provider/supplier/ and/or beneficiary until June 5th. In this situation, 5 of the 45 allotted calendar days will have already passed before the contractor requested the additional information. Upon receiving the information back from the provider/supplier and/or beneficiary, the contractor has 40 calendar days left to process the claim and notify the individual that filed the claim of the payment determination for that claim.

Contractors shall follow existing procedures relative to both the length of time the provider/supplier and/or beneficiary is afforded to return information requested in the development letters and situations where the provider/supplier and or beneficiary does not respond.

Contractors shall report the number of other-than-clean claims processed in 45 days or less on Form Y of the Contractor Reporting of Operational and Workload Data (CROWD) report. Use identifier code "0005" in column 1 to report this information. Report the number of other-than-clean claims processed in 46 days or longer on Form Y of the CROWD system, under column 1 on a line using code "0006" as the identifier.

The following types of claims do not apply to this instruction:

- Claims where the Social Security Administration blocks a beneficiary's *Medicare beneficiary identifier*,
- Claims the contractors are required to hold due to CMS instructions,
- Translator rejects,

- Claims where CWF is unable to process due to technical issues with the CWF beneficiary record or beneficiary identification issues,

- Claims submitted by a hospice, and

- Claims in development due to processing requirements (e.g. medical review), in Publication 100-8, the Medicare Program Integrity Manual.

80.4 - Enforcement of Provider Billing Timelines and Accuracy Standard to Continue PIP (Periodic Interim Payment)

(Rev. 4201, Issued: 01-18-19, Effective: 02-19-19, Implementation: 02-19-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

A. General

To remain on PIP, providers, (with the exception of HHAs that do not receive PIP with the advent of PPS mandated by law on October 1, 2000), must submit 85 percent of their bills timely and accurately. Timely and accurately means that 85 percent of its bills (excluding those listed below) are submitted within 30 days of discharge and pass front-end edits for consistency and completeness. A bill is not considered received unless it can pass FI edits. FIs must accumulate statistics on inpatient and SNF billing performance for each PIP provider to monitor whether it meets this requirement. These instructions do not effect bi-weekly payments for pass-throughs (Medicare Provider Reimbursement Manual, (PRM) §2405.2) and for adjustments to indirect cost for medical education (PRM §2405.3).

The evaluation for timeliness of billing should be consistent with the frequency for monitoring the payment amounts under the PIP program. Thus, for non-PPS hospitals and SNFs the evaluation process is scheduled at 3-month intervals and PPS providers are evaluated every 4 months. The evaluation includes data from the entire 3- or 4-month period. In determining whether a provider submitted its bills within 30 days of discharge or through date on interim bills, count the date from Form CMS-1450 FL6 (through date) to the date received by the FI. If the provider does not meet the criteria, discontinue PIP immediately. The periodic performance report that is provided in accordance with subsection B will constitute advance notice before discontinuing PIP.

Exclude the following:

- MSP cases (value codes 12-16);
- Any special situation identified by the provider or FI that is documented as beyond provider control. Exclusions must be approved by the RO; and
- Bills that have not passed FI front-end edits for acceptance. (Such bills are counted only when acceptable to the shared system edit processes.)

The FIs must accumulate statistics monthly and summarize them for the entire evaluation period.

B. Procedure for Measuring and Reporting to Hospitals and SNFs

The FIs accumulate a record for each bill that passes front-end edits. Bills must be counted in the month received regardless of the discharge month. No later than 10 work-days after the end of the month, FIs furnish a report to each hospital/SNF. For the month indicating the following:

- The total number of bills received;
- The number not excluded as described in section A;
- The number not excluded received in 30 days or less;
- The percentage not excluded received in 30 days or less.

Also, for providers that fail to meet the standard, furnish individual case identification of claims that were not billed within 30 days of discharge. List only claims that are not excluded and are identified in subsection A. The report must be furnished in electronic media, unless the FI determines a paper listing would be cheaper to process. If electronic media is used, use the following record format. Determine the physical characteristics of the file.

Fld	Description	Psn.	Picture	Just	From	Thru
1	Provider Number	6	X(6)	L	001	006
2	Blank	3	X(3)		007	009
3	Blank	1	X		010	
4	*Medicare beneficiary identifier*	12	X(12)	L	011	022
5	Blank	1	X		023	
6	Beneficiary Surname	6	X(6)	L	024	029
7	Blank	1	X		030	
8	Patient Control Number	17	X(17)	L	031	047
9	Blank	1	X		048	
10	From Date	6	9(6)		049	054
11	Blank	1	X		055	
12	Discharge or Thru Date	6	9(6)		056	061
13	Blank	1	X		062	
14	Date Bill Received	6	9(6)		063	068
15	Blank	1	X		069	
16	Days Elapsed	4	9(4)	R	070	073

If sub-provider identification is used, positions 7, 8, and 9 may be utilized.

C. Reinstatement of PIP

Do not reinstate PIP for a provider until it meets all criteria in PRM §§2405.1.B and 2407 and has met the requirements in subsection A for timeliness and accuracy for six consecutive months.

D. New Request for PIP

Evaluate new requests for PIP as in subsections A and B. At least three months experience is required for new requests, (except for new providers with less experience).

E. Hospitals on 100 Percent PRO Prepayment Review

The 30-day requirements for submitting bills to FIs are not applicable. The RO makes determinations of timely and accurate bill submission by hospitals for which the PRO reviews 100 percent of the discharges before payment. However, other standards remain applicable for retaining PIP in such cases. See PRM §§2405.1.B and 2407 for the requirements.

120.2 - Exact Duplicates

(Rev. 4201, Issued: 01-18-19, Effective: 02-19-19, Implementation: 02-19-19)

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Exact duplicates are controlled by the claims processing system through "hard coded" edits, and may not be user-controlled. In addition, Medicare contractors cannot override or bypass exact duplicate edits.

A. Submission of Institutional Claims

Claims or claim lines that have been determined to be an exact duplicate are rejected and do not have appeal rights. An exact duplicate for institutional claims is a claim or claim line that exactly matches another claim or claim line with respect to the following elements:

- *Medicare beneficiary identifier*;
- Type of Bill;
- Provider Identification Number;
- From Date of Service;
- Through Date of Service;
- Total Charges (on the line or on the bill); and
- HCPCS, CPT-4, or Procedure Code modifiers.

Additional Instructions for Institutional Claims:

Whenever any of the following claim situations occur, the MAC develops procedures to prevent duplicate payment of claims. This includes, but is not limited to:

- Outpatient payment is claimed where the date of service is totally within inpatient dates of service at the same or another provider. Do not consider outpatient services provided on the day of discharge within the inpatient dates of service.

- Outpatient bill is submitted for services on the day of an inpatient admission or the day before the day of admission to the same hospital.

- Outpatient bill overlaps an inpatient admission period.

- Outpatient bill for services matches another outpatient bill with a service date for the same revenue code at the same provider or under a different provider number.

1. History File - Paid Claims

The MACs and legacy claims administration contractors must maintain a history file containing information about each claim processed. The file may consist of the claim or information from it. It must contain the following minimum information:

  - *Medicare beneficiary identifier*;
  - Beneficiary name information;
  - Provider identification (name or number); and
  - Billing period from the claim.

Claims or claims information in the history file may be transferred to inactive files. However, the MAC must have the facility to recall such claims or information if a claim for the beneficiary involving the same time period is received.

2. History File - Pending Claims

Contractors must have controls to prevent a duplicate claim from being paid while two claims are in the process within the system at the same time. This may be accomplished through a special check of in-process claims or in the history file for paid claims. The file should contain the same minimum information indicated in the subsections below. The check should be performed prior to sending the claim to CWF.

3. Analysis of Patterns of Duplicate Claims

The contractors shall establish a system for continuing analysis of duplicate claims. This includes the systematic evaluation of returned “Medicare Summary Notices” from beneficiaries and communications from providers indicating a duplicate payment has been made, as well as returned checks from any payee.

The contractor’s system should provide for analyzing duplicate claim receipts to determine whether certain providers are responsible for duplicates and, if so, identify those providers. The contractor should educate

such providers to reduce the number of duplicates they submit. Should those providers continue to submit duplicate claims, the MAC should initiate program integrity action.

B. Claims Submitted by Physicians, Practitioners, and other Suppliers (except DMEPOS Suppliers)

Claims or claim lines that have been determined to be exact duplicates of another claim or claim line are denied. However, such denials may be appealed. An exact duplicate for physician and other supplier claims submitted to a MAC or carrier is a claim or claim line that exactly matches another claim or claim line with respect to the following elements:

- *Medicare beneficiary identifier*;
- Provider Number;
- From Date of Service;
- Through Date of Service;
- Type of Service;
- Procedure Code;
- Place of Service; and
- Billed Amount.

C. Claims Submitted by DMEPOS Suppliers

Claims or claim lines that have been determined to be exact duplicates of another claim or claim line are denied. Such denials may not be appealed. An exact duplicate for DMEPOS supplier claims submitted to a DME MAC is a claim or claim line that exactly matches another claim or claim line with respect to the following elements:

- *Medicare beneficiary identifier*;
- From Date of Service;
- Through Date of Service;
- Place of service;
- HCPCS code;
- Type of Service;
- Billed Amount;
- Supplier

D. Claims Submitted by Multiple DMEPOS Suppliers

When a second DMEPOS supplier or multiple DMEPOS suppliers submit a claim during a span date already approved for the same beneficiary for a different DMEPOS supplier, the DME MAC shall deny the second or subsequent DMEPOS supplier's claim as a duplicate not a suspect duplicate when the following conditions are met:

- Same Beneficiary *Medicare beneficiary identifier*
- Overlapping span Date of Service (DOS) (From DOS and Through DOS)
- Same Healthcare Common Procedure Coding System (HCPCS) Code,
- Same Type of Service on the incoming claim matches a previously approved claim in history, and
- The item is a diabetic testing supply

- **Items Subject to Duplicate Editing**

    1. Diabetic Testing Supplies

130.1 - General Rules for Submitting Adjustment Requests

(Rev. 4201, Issued: 01-18-19, Effective: 02-19-19, Implementation: 02-19-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

Adjustment requests are the most common mechanism for changing a previously accepted bill. They are required to reflect the results of QIO medical review. CMS may also require adjustments if it discovers that bills have been accepted and posted in error to a particular record. Adjustments that only recoup or cancel a prior payment are "credits" and must match the original in the following fields:

- Intermediary control number (ICN/DCN);
- Surname;
- *Medicare beneficiary identifier*

When a definite match cannot be made on the three fields above, the provider's FI will use the fields below as needed. Note that for older claims, ICN/DCN probably will not match.

- Date of birth;
- Admission Date for inpatient, (Date of First Service for outpatient) unless changed by this adjustment requests; and
- From/thru dates for inpatient, (Date of First Service/Date of Last Service for Outpatient), unless changed by this adjustment request.

Cancel-only adjustment requests are not acceptable, except in cases of incorrect provider identification numbers and incorrect *Medicare beneficiary identifier*. The provider must submit a corrected replacement bill (bill type xx1) to its FI after submitting the cancel-only request for the incorrect bill.

The provider must submit all other adjustment requests as debits only. It shows the ICN/DCN of the bill to be adjusted as described above, with the bill type shown as xx7. It submits adjustment requests to its FI either electronically or on hard copy. Electronic submission is preferred.

The FI must enter the following bill types that relate to the entity generating the adjustment request:

xx7	Provider (debit)
xx8	Provider (cancel)
xxF	Beneficiary
xxG	CWF
xxH	CMS
xxI	FI
xxM	MSP
xxP	QIO
xxJ	Other
xxK	OIG/GAO

The provider submits all adjustment requests as bill type xx7 or xx8. Since several different sources can initiate an MSP adjustment (e.g., the provider, CWF, or the FI), the MSP designation, xxM, takes priority over any other source of an adjustment except OIG/GAO. When the provider submits an MSP adjustment request to the FI, the FI will change the bill type to xxM. These priorities refer only to the designation of the source of the adjustment. The difference between CWF generating the adjustment request and CMS generating the adjustment request is:

An adjustment request is CWF-generated if the FI receives a CWF alert or a CMS-L1002.

The FI prepares an adjustment if instructed by CMS CO or CMS RO to make a change. Typically, the FI receives such direction from CMS when it decides to retroactively change payment for a class or other group of bills. Occasionally, CMS will discover an error in the processing of a single bill and direct the FI to correct it.

If the FI furnished the Part B carrier a copy of the original bill that is being adjusted, it must furnish the carrier a copy of the adjusted bill.

If adjustments are rejected by CWF for additional corrections, they must be corrected and resubmitted.

Even if a letter from CMS requests the adjustment action, the FI must submit the adjustment request in its

CWF record. If a rejected adjustment request is determined to be unnecessary, the FI stops the adjustment action upon receipt of correction.
Where an adjustment request changes subsequent utilization, the FI notes this and processes adjustments to subsequent bills if it services the provider.
If the FI does not service the provider, CMS will contact the FIs that submitted bills with subsequent billing dates that are affected by the adjustments via a CMS-L389 or CMS-L1001 upon receipt of the adjusted bills in CWF. (An indicator is set by CMS on its records upon advising a FI of the appropriate adjustment actions.)

130.1.2.1 - Claim Change Reason Codes

(Rev. 4201, Issued: 01-18-19, Effective: 02-19-19, Implementation: 02-19-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

The provider submits one of the following claim change reason codes to its FI with each debit-only or cancel-only adjustment request:

Bill Type	Reason Code	Explanation
Xx7	D0 (zero)	Change to service dates
Xx7	D1	Change in charges
Xx7	D2	Change in revenue codes/HCPCS - HIPPS
Xx7	D3	Second or subsequent interim PPS bill - PPS inpatient hospital only
Xx7	D4	Change in GROUPER input (diagnoses or procedures) - PPS inpatient hospital).
Xx8	D5	Cancel-only to correct a *Medicare beneficiary identifier* or provider identification number
Xx8	D6	Cancel-only to repay a duplicate payment or OIG overpayment (includes cancellation of an outpatient bill containing services required to be included on the inpatient bill.)
Xx7	D7	Change to make Medicare the secondary payer
Xx7	D8	Change to make Medicare the primary payer
Xx7	D9	Any other change
Xx7	E0 (zero)	Change in patient status

The provider may not submit more than one claim change reason code per adjustment request. It must choose the single reason that best describes the adjustment it is requesting. It should use claim change reason code D1 only when the charges are the only change on the claim. Other claim change reasons frequently change charges, but the provider may not "add" reason code D1 when this occurs.

The claim change reason code is entered as a condition code on the hard copy Form CMS-1450 or the electronic equivalent. For reason codes D0-D4 and D7-D9, the biller submits a debit-only adjustment request, bill type xx7. For reason codes D5 and D6, it submits a cancel-only adjustment request, bill type xx8.

130.1.3 - Late Charges

(Rev. 4201, Issued: 01-18-19, Effective: 02-19-19, Implementation: 02-19-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new

Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

The provider submits late charges on bills to the FI as bill type xx5. These bills contain only additional charges. However, if the late charge is for:

- Services on the same day as outpatient surgery subject to the ASC limit;

Services on the same day as services subject to OPPS;

- ESRD services paid under the composite rate;
- Inpatient accommodation charges;
- Services paid under HH PPS; and
- Inpatient hospital or SNF PPS ancillaries.

It must be submitted as an adjustment request.

The provider may submit the following charges omitted from the original paid bill to the FI as late charges:

- Any outpatient services other than the exceptions stated in this paragraph. This includes late charges for non-HH PPS services under Part B, hospice services other than the services of hospice-employed attending physicians, hospital outpatient services except those on the day of ambulatory surgery subject to the ASC payment limitation or the day of outpatient services subject to OPPS, RHC services, OPT services, SNF outpatient services, CORF services, FQHC services, CMHC services, ESRD services not included in the composite rate; and
- Any inpatient SNF ancillaries or inpatient hospital ancillaries other than from PPS providers. The provider may not submit late charges (xx5) for inpatient hospital or SNF accommodations. The provider must submit these as adjustments (bill type xx7).

The FI has the capability to accept xx5 bill types electronically and process them as initial bills except as described in the following paragraph.

The FI also performs the following edit routines on any xx5 type bills received:

- Pass all initial bill edits, including duplicate checks.
- Must not be for any of: Inpatient hospital or SNF PPS ancillaries, inpatient accommodations in any facility, services on the same day as outpatient surgery subject to the ASC payment limitation, services on the same day as services subject to OPPS, or ESRD services included in the composite rate. These are rejected back to the hospital with the message, "This change requires an xx7 debit-only or xx8 cancel-only request from you. Late charges are not acceptable for inpatient PPS ancillaries, inpatient accommodations in any facility, services on the same day as outpatient surgery subject to the ASC payment limitation, services on the same day as services subject to OPPS, or ESRD services included in the composite rate."
- When an xx5 suspends as a duplicate, (dates of service equal or overlapping, provider ID equal, *Medicare beneficiary identifier* equal, and patient surname equal), the FI must determine the status of the original paid bill. If it is denied, the FI must deny the late charge bill.
- If an xx5 does not suspend as a potential duplicate, the FI rejects it back to the provider with the message, "No original bill paid. Please combine and submit a single original bill (xx1)."
- If the original bill was approved and paid, the FI compares the revenue codes on the original paid bill with the associated late charge bill:
    - For all providers (any bill type), if any are the same, and are revenue codes 41x, 42x, 43x, 44x, 63x, 76x, or 91x, the FI rejects the bill back to the provider with the message, "You must submit an adjustment (xx7) to the original paid bill. Revenue codes subject to utilization review are duplicated on the late charge bill."
    - For HHA services not under a plan of care (bill type 34x), the FI must apply the same logic for the following additional revenue codes. If any are the same and are revenue codes 27x, 29x, 55x, 56x, 57x, 58x, 59x, 60x, or 63x, the FI rejects the bill back to the provider with the message, "You must submit an adjustment (xx7) to the original paid bill. Revenue codes subject to utilization review are duplicated on the late charge bill."
    - For hospital outpatient services (bill type 13x only), the FI must apply the same logic for the following additional revenue codes. If any are the same and are revenue codes 255, 32x, 33x, 34x, 35x, 40x, 62x, 73x, 74x, 92x, or 943, the FI rejects the bill back to the hospital with the

message, "You must submit an adjustment (xx7) to the original paid bill. Revenue codes subject to utilization review are duplicated on the late charge bill."

- For RDFs (bill type 72x or 73x), the FI must apply the same logic for the following additional revenue codes; if any are the same and are revenue codes 634, 635, 82x, 83x, 84x, 85x, or 88x, the FI rejects the bill back to the provider with the message, "You must submit an adjustment (xx7) to the original paid bill. Revenue codes subject to utilization review are duplicated on the late charge bill."

- If the late charges bill relates to two or more "original" paid bills, and one of these is denied, the FI must suspend and investigate the late charge bill.
- The FI must compare total charges on the original paid bill with those on the associated late charge bill, and suspend and investigate any xx5 bill type with total charges in excess of those on the original paid bill. This edit suggests the provider may have rebilled the already paid services.

The FI may decide to perform additional edits on late charge bills.

130.2 - Inpatient Part A Hospital Adjustment Bills

(Rev. 4201, Issued: 01-18-19, Effective: 02-19-19, Implementation: 02-19-19)

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For adjustment requests reported as a claim record, the hospital must report the ICN/DCN of the original bill. See the ASC X12 Institutional Claim Implementation Guide for instructions for the electronic format and Chapter 25 for instructions for Form CMS-1450. Where payment is handled through the cost reporting and settlement processes, the hospital accumulates a log for those items not requiring an adjustment request. For cost settlement, the A/B MAC (A) pays on the basis of the log. This log must include:

- Patient name;
- *Medicare beneficiary identifier*;
- Dates of admission and discharge, or from and thru dates;
- Adjustment in charges (broken out by ancillary or routine service); and
- Any unique numbering or filing code necessary for the hospital to associate the adjustment charge with the original billing.

NOTE: Hospitals in Maryland, which are not paid under PPS or cost reports, submit an adjustment request for inpatient care of $500 or more, and keep a log as described above for lesser amounts. Because there are no adjustment requests, the A/B MAC (A) enters the payment amounts from the summary log into the PPS waiver simulation and annually pays the items on the log after the cost report is filed.

After cost reports are filed, the A/B MAC (A) makes a lump sum payment to cover these charges as shown on the summary log. The hospital uses the summary log for late charges only under cost settlement (outpatient hospital), except in Maryland.

Maryland and cost hospitals are required to meet the 12-month timeframe for timely filing of claims, including late charges.

For all adjustments other than QIO adjustments (e.g., provider submitted adjustments and/or those the A/B MAC (A) initiates), the A/B MAC (A) submits an adjustment request to CWF following its acceptance of the initial bill. To verify CMS's acceptance, the A/B MAC (A) can submit a status query.

Under inpatient hospital prospective payment, adjustment requests are required from the hospital where errors occur in diagnosis and procedure coding that changes the DRG, or where the deductible or utilization is affected. A hospital is allowed 60 days from the date of the A/B MAC (A) payment notice (remittance

advice) for adjustment requests where diagnostic or procedure coding was in error resulting in a change to a higher weighted DRG. Adjustments reported by the QIO have no corresponding time limit and are adjusted automatically by the A/B MAC (A) without requiring the hospital to submit an adjustment request. However, if diagnostic and procedure coding errors have no effect on the DRG, adjustment requests are not required.

Under PPS, for long-stay cases, hospitals may bill 60 days after an admission and every 60 days thereafter if they choose. The A/B MAC (A) processes the initial bill through Grouper and PRICER. When the adjustment request is received, it processes it as an adjustment. In this case, the 60-day requirement for correction does not apply.

130.3.1 - Tolerance Guides for Submitting SNF Inpatient Adjustment Requests

(Rev. 4201, Issued: 01-18-19, Effective: 02-19-19, Implementation: 02-19-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

SNF inpatient adjustment requests adhere to the same billing instructions as non-inpatient adjustment requests with the following changes. When an initial bill has been submitted and the provider or FI discovers an error on the bill, an adjustment request is submitted if the change involves one of the following:

- A change in the Part B cash deductible of more than $1.00
- A change in the number of inpatient days;
- A change in the blood deductible;
- A change in provider number;
- A change in coinsurance which involves an amount greater than $1.99;
- A change in the HIPPS code to correct a data input error or,
- Effective for changes for services June 1, 2000, change in HIPPS code due to an MDS correction. (Such adjustments are required within 120 days of the through date on the initial bill.) **NOTE:** See Chapter 6, Section 35 for information on submitting adjustments to HIPPS codes resulting from MDS corrections.

Late charge billings (type of bill xx5) are not acceptable for SNF PPS Part A services.
The reason for an adjustment (Claim Change Reasons) is reported in one of the condition code fields. Claim Change Reason Codes applicable to SNFs are:

D0	Changes to Service Dates	D6	Cancel only to repay a duplicate OIG payment
D1	Changes to Charges	D7	Change to Make Medicare Secondary Payer
D2	Changes in Revenue codes/ HCPCS - HIPPS	D8	Change to Make Medicare Primary Payer
D4	Changes in Grouper code	D9	Any Other Change
D5	Cancel to correct *Medicare beneficiary identifier* or Provider ID	E0	Change in Patient Status

The SNF selects the one code that best describes the change reason. An adjustment may contain multiple changes even though only one reason code is reported.

130.5.1 - Submitting Adjustment Requests

(Rev. 4201, Issued: 01-18-19, Effective: 02-19-19, Implementation: 02-19-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

A home health agency submits a corrected Form CMS-1450 if any of the following apply:

- A change in provider number;
- A change in coinsurance involves an amount greater than $1.99; or
- A change in visits (decrease or increase).

Where there are money adjustments other than a coinsurance amount greater than $1.99, the agency records the difference on a record sufficiently documented to establish an accounting data trail, including patient's name and *Medicare beneficiary identifier*, first and last dates of services, and any unique numbering or filing code necessary to associate the adjustment charge with the original billing.
A number of conditions can cause the episode payment to be adjusted. Both RAPs and claims may be cancelled by HHAs if a mistake is made in billing (TOB 328), though episodes will be cancelled in CWF as well. Adjustment claims may also be used to change information on a previously submitted claim (TOB 327), which may also change payment. RAPs can only be cancelled, not adjusted, but may be re-billed after cancellation.

130.6 - Adjustments to Reprocess Certain Claims Denied Due to an Open Common Working File (CWF) Medicare Secondary Payer (MSP) Group Health Plan (GHP) Record Where the GHP Record Was Subsequently Deleted or Terminated

(Rev. 4201, Issued: 01-18-19, Effective: 02-19-19, Implementation: 02-19-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

Group Health Plan (GHP) Medicare Secondary Payer claims were not reprocessed automatically in situations where Medicare becomes the primary payer after an MSP GHP record was deleted, or when an MSP GHP record was terminated, after claims were processed subject to the CWF record. It was the responsibility of the beneficiary, provider, physician or other supplier to contact the Medicare contractor and request the denied claims be reopened when reopening was permitted. This was a burden on the beneficiary, physician, or other supplier. This instruction directs CWF to implement an automated process to reopen certain MSP claims when MSP GHP records were 1) deleted, or 2) under some circumstances, certain MSP GHP records were terminated and claims were denied (rejected for Part A claims) due to MSP or Medicare made a secondary payment before the termination date was accreted.

The COBC currently identifies, deletes, and terminates MSP GHP records on the CWF when appropriate. The 1-800 Medicare also applies simple terminations to MSP GHP working aged records only. Upon deletion of an MSP record, or where a termination dated added to an MSP GHP (MSP Codes 12, 13, 43) record, this instruction directs the CWF to search the claims history for claims, with dates of service within 180 days of the deletion date, or the date the termination date was applied, which were processed for secondary payment or were denied because of the MSP edit as set forth in 42 CFR 405, subpart G, H and I. The Shared Systems shall reopen these claims, as necessary, including locating any claims billed to Medicare as primary, or secondary, and denied (rejected for Part A claims) on the basis of the subsequently deleted CWF MSP GHP record. Claims with added termination dates shall be reopened no earlier than the termination date applied to CWF.

The CWF shall generate an unsolicited response "W" and send this response with the 24 and 10 trailers containing the identifying information regarding any such claims found to the shared system. The

unsolicited response shall include all the necessary information to identify the claim(s), including the Document Control Number/Internal Control Number/Claim Control number, *Medicare beneficiary identifier*, beneficiary name, and date(s) of service. The CWF electronically transmits this unsolicited response to the claims processing contractor(s) that originally processed the claim(s) or send the claim to the MAC contractor that assumed the workload for the original legacy contractor that processed the claim. The previously denied claim(s) (rejected for Part A) is not to be canceled and remains on the CWF claims history pending subsequent adjustment as warranted.

Upon receipt of the unsolicited response, the shared system software reads the claim information in the trailer for each claim and performs an automated reopening to each claim. The claim(s) must be reopened and adjusted as warranted for all non-reimbursed/claim denials (part A rejections)/ where Medicare paid secondary or terminations that were based upon the MSP GHP record that was just deleted or terminated. The MSP unsolicited responses are reported with the current MSP responses when COB deletes an MSP record a "03" will be received. The shared systems release the adjusted claims. Adjustments are subject to all applicable edits as the original claim(s) and sent to the CWF so that the claim(s) on the CWF history are replaced with the adjusted claim(s) records.

The automated MSP GHP reprocessing requirement allows CWF to alert the shared system when a MSP GHP record is deleted or a termination date added for specific beneficiaries. The shared systems and Medicare Contractors receive an IUR transaction response from CWF alerting the system to reprocess certain MSP GHP claims where the open GHP record was deleted /terminated by the Coordination of Benefits Contractor (COBC) or 1-800-Medicare. This unsolicited transaction is sent to the contractors on record at CWF who had claim history for the associated beneficiary within the 180 day period. The CWF system is already programmed to send an updated MSP transaction (HUSC transaction) any time a change is made to an MSP record and this process does not change.