CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2670	**Date: March 14, 2013**
	Change Request 7260

Transmittal 2449, dated April 26, 2012, is being rescinded and replaced by Transmittal 2670 to restore the Common Working File (CWF) entitlement validation criterion to that used prior to the implementation of CR 7260. Changes were made to business requirements (BRs) 7260.1 and 7260.1.1. All other information remains the same.

SUBJECT: Modification to CWF, FISS, MCS and VMS to Return Submitted Information when there is a CWF Name and HIC Number Mismatch.

I. SUMMARY OF CHANGES: This CR changes the current CWF and shared system processes so that if there is a HICN and name mismatch within CWF, the submitter will receive the information it originally submitted when the claim is returned.

EFFECTIVE DATE: October 1, 2012
IMPLEMENTATION DATE: October 1, 2012; April 1, 2013 for BRs 7260.1 and 7260.1.1

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.

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	27/ 20. 2.2.6/ Disposition Code 55 (Personal Characteristic Mismatch)

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not 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

**Unless otherwise specified, the effective date is the date of service.*

Attachment – Business Requirements

Pub. 100-04	Transmittal: 2670	Date: March 14, 2013	Change Request: 7260

Transmittal 2449, dated April 26, 2012, is being rescinded and replaced by Transmittal 2670 to restore the Common Working File (CWF) entitlement validation criterion to that used prior to the implementation of CR 7260. Changes were made to business requirements (BRs) 7260.1 and 7260.1.1. All other information remains the same.

SUBJECT: Modification to CWF, FISS, MCS and VMS to Return Submitted Information when there is a CWF Name and HIC Number Mismatch

Effective Date: October 1, 2012

Implementation Date: October 1, 2012; April 1, 2013 for BRs 7260.1 and 7260.1.1

I. GENERAL INFORMATION

A. Background: When the Common Working File (CWF) receives a valid Health Insurance Claim Number (HICN) with a name that does not match the name associated with that HICN in the CWF record, the CMS shared processing systems assume that the submitter made a mistake in listing the name. Accordingly, when the contractor rejects the claim, it returns the name of the beneficiary that is associated with that HICN within CWF. If the submitter has made an error when entering the HICN, this will likely result in the submitter receiving information belonging to a patient the provider has not treated. This CR changes the current CWF and shared system processes so that if there is a HICN and name mismatch within CWF, the submitter will receive the information it originally submitted when the claim is returned. We are also eliminating from §20.2.2.6 the bullet point that required the Host to return what it believed to be the proper information on Trailer 10.

B. Policy: In accordance with existing CMS policy, provider submitted claims shall be handled differently than beneficiary submitted claims as indicated in the following business requirements.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7260.1	All claims sent to CWF for entitlement verification as well as CWF provider entitlement inquiries shall be matched against the CMS entitlement files utilizing the same criterion that was in use prior to the implementation of CR 7260.									X	
7260.1.1	If CWF fails to verify criteria used to match the information as per BR7260.1, then on claims and HUSP transactions, the edit 55 shall be set with a “5052” and trailer of 08.									X	

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7260.2	As of the effective date of this CR, regardless of the date of service or the claim's date of receipt, when a provider submitted claim is returned to the contractor with a disposition code of 55, an error code of 5052, and a trailer of 08, FISS, MCS and VMS shall take action that will result in the submitter receiving information about the disposition of the claim without the need for manual intervention by the Medicare contractor. The returned information shall contain the name and HICN with which the original claim was submitted. (Each shared processing system will handle this situation differently as provided for in the following business requirements.)						X	X	X		
7260.2.1	FISS shall create a reason code that shall result in the provider submitted claim being returned to the provider (RTP'd) by the Medicare contractor when CWF returns the edit, trailer and disposition codes referred to in 7260.1.1						X				
7260.2.1.1	FISS shall ensure that the reason code it creates as per 7260.2.1 shall result in the RTP returning to the provider the name and HICN that was originally submitted on the claim without the need for manual intervention by the Medicare contractor.						X				
7260.2.2	The Medicare contractors shall use CWF Error Code File and the Narrative Files RJ message action to automatically return provider submitted claims with the CWF replies it receives with the disposition codes referred to in 7260.1.	X			X						
7260.2.2.1	MCS shall ensure that when the process referred to in 7260.2.2 is utilized, the provider submitted claim shall be returned as unprocessable utilizing the beneficiary related data submitted with the original claim on the provider remittance advice without the need for manual intervention by the Medicare contractor, other than to perform the maintenance indicated in 7260.2.2.							X			

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7260.2.3	When VMS receives from CWF the trailer, disposition, and error codes as described in 7260.1, VMS shall systematically return the provider submitted claim as unprocessable without the need for Medicare contractor manual intervention.		X						X		
7260.2.3.1	When VMS receives from CWF the disposition and edit codes described in 7260.1.1 for HUSP transactions, VMS shall not change the name for the HICN on the Beneficiary master record.								X		
7260.3	When returning these claims as unprocessable as per 7260.2.2 and 2.3, the shared systems and Medicare contractors shall utilize ANSI remittance advice codes MA130 and MA61. This requirement does not apply to claims processed by FISS and returned to the provider as per 7260.2.1.	X	X		X			X	X		
7260.3.1	When returning MCS and VMS provider submitted claims as unprocessable as per 7260.3, Medicare contractors shall use Reason Code 140 (Patient/Insured health identification number and name do not match).	X	X		X						
7260.3.2	Because CMS was unable to confirm the submitted HICN, both provider and beneficiary submitted claims receiving the indicated CWF response as per 7260.1 and 7260.1.1 shall not be included in the Medicare Summary Notice (MSN) for the submitted HIC number. (CMS is aware that claims that are RTP'd as per 7260.2.1 do not currently generate a MSN entry.)						X	X	X		
7260.4	Beneficiary submitted claims receiving a disposition code of 55, an error code of 5052 and a trailer of 08, shall be suspended and handled in accordance with Pub.100-4. Chapter 27, 20.2.2.6 – Disposition Code 55 (Personal Characteristic Mismatch) and Pub. 100-04, Chapter 1, Section 80.3.2. - Handling Incomplete or Invalid Claims, Subsection A,	X	X		X						

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	"Special Considerations." In accordance with the latter instruction, contractors shall send a letter to the beneficiary explaining which information is missing, incorrect or invalid.										
7260.5	As of the effective date of this CR, when an adjustment claim is returned to the contractor with a disposition code of 55, an error code of 5052, and a trailer of 08, FISS, MCS and VMS shall cause the adjustment to suspend.						X	X	X		
7260.5.1	The Medicare contractor shall review the suspended adjustment claim referred to in 7260.5 and correct, develop or delete the adjustment as appropriate.	X	X	X	X	X					
7260.6	The preceding business requirements shall apply to all claims receiving the indicated CWF response as per 7260.1 and 7260.1.1 as of the effective date of this change request regardless of the date of service or the original claim's date of receipt.	X	X	X	X	X	X	X	X		

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7260.7	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is scheduled. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in the Contractors 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	X					CEDI

IV. SUPPORTING INFORMATION

A. Recommendations and supporting information associated with listed requirements:

X-Ref Requirement Number	Recommendations or other supporting information:
	N/A

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

V. CONTACTS

Pre-Implementation Contact(s): Scott Levine (Scott.Levine@cms.hhs.gov or 212-616-2337).

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING:

A. ***For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),*** **and/or** ***Carriers*****:**

No additional funding will be provided by CMS. Contractor activities are to be carried out within their current operating budgets.

B. ***For Medicare Administrative Contractors (MAC)*****:**

The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). 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.

20.2.2.6 - Disposition Code 55 (Personal Characteristic Mismatch)

(Rev.2670, Issued: 03-14-13, Effective: 10-01-12, Implementation: 10-01-12; April 1, 2013 for BRs 7260.1.1)

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:*

Contractors shall return to provider (RTP) Part A claims. Contractors shall not mail an MSN for these claims.

Contractors shall return as unprocessable Part B *provider submitted* claims. Contractors shall use Reason Code 140 (Patient/Insured health identification number and name do not match). Contractors shall not mail an MSN for these claims. *When returning these claims as unprocessable, the shared processing system and Medicare contractor shall utilize ANSI remittance advice codes MA130 and MA61.*

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