CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 4415	**Date: October 11, 2019**
	Change Request 11113

SUBJECT: Medicare Administrative Contractor (MAC) Guidance Related to Use of Adjustment Codes on Adjustment Claims

I. SUMMARY OF CHANGES: The purpose of this CR is to refine the claim adjustment reporting process, where necessary, to achieve better consistency in the grouping of all claim adjustments across the Medicare Administrative Contractors (MACs) into one of the following three groups, defining the origin of the adjustment request: CMS, the MAC, or the Provider. To this end, this CR directs the MACs to use specific Shared System codes whenever it is determined that an adjustment directly originates from one of these three entities. This direction applies to any adjustments (mass adjustments or otherwise) that are not currently directed to use another code. This CR does not direct MACs to change current code usage, but rather to provide direction where to report adjustments for which no previous direction has been received. This CR also directs the Health Insurance General Ledger Accounting System (HIGLAS) to map the new codes.

EFFECTIVE DATE: January 1, 2020
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 6, 2020

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	Ch. 1/Table of Contents
N	1/130/130.7 - MAC Guidance Related to Use of Adjustment Codes on Adjustment Claims

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: 4415**	**Date: October 11, 2019**	**Change Request: 11113**

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EFFECTIVE DATE: January 1, 2020
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IMPLEMENTATION DATE: January 6, 2020

I. GENERAL INFORMATION

A. Background: CMS found that MACs are using adjustment reason codes inconsistently and that there are gaps in the current list of codes available. The purpose of this CR is to refine the claim adjustment reporting process, where necessary, to achieve better consistency in the reporting of claim adjustments across the Medicare Administrative Contractors (MACs).

The Shared Systems use different terminology for the adjustment codes. In FISS, the adjustment codes we refer to in this CR are called Claim Frequency Codes. In MCS, the adjustment codes we refer to in this CR are called method of discovery codes. In VMS, the adjustment codes we refer to in this CR are called accounting discovery codes.

Currently, there may be some subjective interpretation of the adjustment codes, particularly the method of discovery codes. In this CR, we are providing definitive direction to the MACs on the use of specific adjustment codes and are creating new codes in MCS to address gaps in the current list of codes, and directing use of existing codes in FISS. This CR will not apply to the DME MACs. A future CR will be written for the DME MACs after the VMS to HIGLAS transition is complete.

For provider initiated adjustments, MACs should continue with their current method of reporting. In this CR, we specify codes that are associated with provider initiated adjustments.

The instructions in this CR will be incorporated into the claims processing manual as well, to ensure reporting remains consistent going forward.

B. Policy: This CR directs the MACs to use specific, defined Shared System codes whenever it is determined that an adjustment directly originates from one of three entities (CMS, MAC, or the Provider). This direction applies to any adjustments (mass adjustments or otherwise) that are not currently directed to use another code. This CR does not direct MACs to change current code usage, but rather to provide direction where to report adjustments for which no previous direction has been received.

II. BUSINESS REQUIREMENTS TABLE

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

Number	**Requirement**	**Responsibility**								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11113.1	MACs shall refine reporting of adjustment codes according to the instructions in this CR. For the claim frequency codes, method of discovery codes, and accounting discovery codes not addressed in this CR, the MACs should continue their current method of reporting	X	X	X						
11113.1.1	The DME MAC and the RRB contractor is waived from requirements in CR 11113 until they transition to HIGLAS.				X					RRB-SMAC
11113.2	Part A A/B MACs shall use Claim Frequency Code "H" when it is determined that CMS is the direct originating entity of an adjustment.	X		X						
11113.3	Part B A/B MACs shall use Method of Discovery Code "12" (CMS) when it is determined that CMS is the direct originating entity of an adjustment and the adjustment does not fall into the existing method of discovery code categories.		X							
11113.3.1	Part B A/B MACs shall add Method of Discovery Code "12" to SPITAB HXXTDSCV in MCS.		X							
11113.3.2	HIGLAS shall map the HIGLAS Discovery Code ‘12’ (CMS) to the existing transaction types and use the demand letters that are configured for these transaction types BPROV-CLA (Provider Non 935) BPROV-CLA-935 (Provider 935) BBENE-CLA (Beneficiary)									HIGLAS
11113.4	Part A A/B MACs shall use Claim Frequency Code "I" when it is determined that MAC is the direct originating entity of an adjustment.	X		X						
11113.5	Part B A/B MACs shall use Method of Discovery Code "13" (MAC) when it is determined that MAC is the direct originating entity of an adjustment.		X							
11113.5.1	Part B A/B MACs shall add Method of Discovery Code "13" (MAC) to SPITAB HXXTDSCV in MCS.		X							
11113.5.2	HIGLAS shall map the HIGLAS Discovery Code ‘13’									HIGLAS

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	(MAC) to the existing transaction types and use the demand letters that are configured for these transaction types BPROV-CLA (Provider Non 935) BPROV-CLA-935 (Provider 935) BBENE-CLA (Beneficiary)									
11113.6	Part A A/B MACs shall use Claim Frequency Code "7" when it is determined that a Provider is the direct originating entity of an adjustment.	X		X						
11113.7	Part B A/B MACs shall use Method of Discovery Code "P" when it is determined that a Provider is the direct originating entity of an adjustment.		X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Stacey Ndelle, 410-786-8208 or Stacey.Ndelle@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

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(Rev. 4415; Issued 10-11-19)

130.7 - MAC Guidance Related to Use of Adjustment Codes on Adjustment Claims

130.7 - MAC Guidance Related to Use of Adjustment Codes on Adjustment Claims
(Rev. 4415; Issued: 10-11-19; Effective: 01-01-20; Implementation: 01-06-20)

The Centers for Medicare & Medicaid Services (CMS) is refining the claim adjustment reporting process to achieve better consistency in the reporting of claim adjustments across the Medicare Administrative Contractors (MACs) and is adding new codes to address gaps in the current list of codes available.

The Shared Systems use different terminology for the adjustment codes. In FISS, the adjustment codes are called Claim Frequency Codes. In MCS, the adjustment codes are called Method of Discovery Codes. In VMS, the adjustment codes are called Accounting Discovery Codes.

CMS is directing the A/B MACs to use claim frequency code "H" when CMS initiates the Part A claim adjustment, such as a mass adjustment directed by CMS to address system issues, and claim frequency code "I" when the A/B MAC identifies and initiates the Part A claim adjustment.

CMS is also creating a new method of discovery code "12" to identify Part B adjustments in MCS that were initiated by CMS, and a new method of discovery code "13" for MAC initiated Part B adjustments in MCS. The A/B MACs should use method of discovery code "12" for CMS-directed adjustments that do not fall into the "C" - CMS Review category or other existing CMS-related method of discovery categories. The A/B MACs should use method of discovery code "13" for MAC identified and initiated adjustments that do not fall into the existing method of discovery code categories, such as method of discovery code "A". The A/B MACs should use method of discovery code "A" for adjustments arising from MAC initiated internal review, such as adjustments to address errors the MAC identified while processing the claim or adjustments due to MAC internal quality reviews.

For provider initiated adjustments, MACs should continue with their current method of reporting (claim frequency code "7" for Part A claims, method of discovery code "P" for Part B MCS claims, and accounting discovery code "D" for Part B DME claims).