CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2331	**Date: August 2, 2019**
	Change Request 11307

SUBJECT: Modifications to the National Coordination of Benefits Agreement (COBA) Crossover Process

I. SUMMARY OF CHANGES: Through this instruction, the Centers for Medicare & Medicaid Services (CMS) takes action to ensure that certain claims submitted without a required diagnosis code or incorrect Claim Adjustment Group Code are handled by our Part A and Home Health and Hospice (HH&H) Medicare Administrative Contractors (MACs) in a standard manner.

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
N/A	N/A

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:

One Time Notification

Attachment - One-Time Notification

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I. GENERAL INFORMATION

A. Background: Currently, like other entities covered under the Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification requirements, Medicare is expected to follow the specifications in both the National Uniform Billing Committee (NUBC) and National Uniform Claims Committee (NUCC) Manuals, as well as the Technical Report Version 3 (TR-3) Implementation Guides with respect to 837 claims transactions. Medicare must also comply with Council for Affordable Quality Healthcare, Inc., Committee on Operating Rules for Information Exchange (CAQH-CORE) requirements governing Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Code (RARC) combinations and associated use of Claim Adjustment Group Codes.

The Centers for Medicare & Medicaid Services (CMS) recently determined it was not consistently following the NUBC Manual guidance concerning the requirement of an Admitting Diagnosis Code on certain institutional facility claims. Per the NUBC Manual, all of the following types of bills (TOBs) require an Admitting Diagnosis Code: 11x (Hospital: Inpatient Part A), 12x (Hospital: Inpatient Part B), 18x (Hospital Swing Beds—Inpatient), 21x (Skilled Nursing Facility: Inpatient Part A), 22x (Skilled Nursing Facility: Inpatient Part B), and 41x (Religious Non-Medical Health Care Institutions--Inpatient). **Note:** The Part A shared system already has edits/reason codes activated to address a missing Admitting Diagnosis Code on 11x, 12x, and 22x TOB claims. Additionally, CMS has determined that Medicare is currently accepting and adjudicating incoming Medicare Secondary Payer (MSP) claims that have an incorrect Group Code (i.e., OA) included with CARC 45. Per the guidance available on the Washington Publishing Company web site and through CAQH-CORE, CARC 45 [defined as "Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement."] may only be used with Group Codes "PR" (patient responsible) and "CO" (contractual obligation), not with other Group Codes such as "OA" (other adjustment) or "PI" (payer-initiated). Medicare is detecting these issues on incoming electronic and hard copy/paper claims and on claims submitted via Direct Data Entry (DDE) methodology. CMS will be addressing Medicare Administrative Contractor (MAC) and shared system requirements relating to incoming hard copy/paper and DDE-submitted claims, as applicable, through this instruction. **Note:** CMS is addressing Contractor Common Edits Module (CCEM) requirements for incoming electronic claims through a separate CMS change request, which is targeted for the January 2020 quarterly systems release. Part B MAC requirements relating to a primary payer's incorrect usage of Group Code OA and PI on incoming MSP claims will be addressed through a future change request.

B. Policy: The Part A shared system shall create a new Return to Provider (RTP) edit/reason code that will activate when an incoming 18x (Hospital Swing Beds—Inpatient), 21x (Skilled Nursing Facility--Inpatient Part A), and 41x (Religious Non-Medical Health Care Institutions--Inpatient) TOB DDE-keyed claim or hard copy UB04 claim is submitted without a required Admitting Diagnosis Code. Upon receipt of the newly created RTP edit/reason code, the Part A MAC shall return the claim to the provider for correction. The Part A shared system shall also create a new reason code that will activate when a provider submits an MSP claim, either via DDE or as a UB04 hard copy with an accompanying primary payer Explanation of Benefits (EOB), that includes a Group Code other than CO or PR used with CARC 45. When the Part A and HH&H MACs receive the newly developed reason code, they shall return the claim to

the provider for correction.

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	
11307.1	The Part A shared system shall create a new RTP edit/reason code that will activate when an incoming 18x (Hospital Swing Beds—Inpatient), 21x (Skilled Nursing Facility--Inpatient Part A), and 41x (Religious Non-Medical Health Care Institutions--Inpatient) TOB DDE-keyed claim or hard copy UB04 claim is submitted without a required Admitting Diagnosis Code. **Note:** The Part A shared system already has edits/reason codes activated to address a missing Admitting Diagnosis Code on 11x, 12x, and 22x TOB claims.					X				
11307.1.1	The Part A shared system shall activate the new reason code based upon a claim's date of receipt.					X				
11307.1.2	The Part A shared system shall ensure that the new reason code is not applied to provider-initiated or contractor-initiated adjustment claims when the associated original claim was processed prior to the implementation of the new reason code.					X				
11307.1.3	Upon receipt of the newly created RTP edit/reason code, the Part A MAC shall return the claim to the provider for correction.	X								
11307.2	The Part A shared system shall create a new reason code that will activate when a provider submits an MSP claim, either via DDE or as a UB04 hard copy with an accompanying primary payer EOB, that includes a Group Code other than CO or PR used with CARC 45 ("Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement").					X				
11307.2.1	The Part A shared system shall activate the new reason code based upon a claim's date of receipt.					X				
11307.2.2	The Part A shared system shall ensure that the new reason code is not applied to provider-initiated or contractor-initiated adjustment claims when the					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	associated original claim was processed prior to the implementation of the new reason code.									
11307.2.3	Upon receipt of the newly developed reason code, the Part A and HH&H MAC shall return the claim to the provider for correction.	X		X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
11307.3	MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the "MLN Matters" listserv to get article release notifications, or review them in the MLN Connects weekly newsletter.	X		X		

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Brian Pabst, brian.pabst@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
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ATTACHMENTS: 0