CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 4233	**Date: February 8, 2019**
	Change Request 11084

SUBJECT: Update to Publication (Pub.) 100-04 Chapters 4 and 17 to Provide Language-Only Changes for the New Medicare Card Project

I. SUMMARY OF CHANGES: This Change Request (CR) contains language-only changes for updating the New Medicare Card Project-related language in Pub 100-04, chapters 4 and 17. 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: March 12, 2019
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: March 12, 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	4/10.7.2.4/Procedures for Medicare Contractors to Perform and Record Outlier Reconciliation Adjustments
R	4/40.4.2/Procedures for Paying Claims Without Passing through the IOCE
R	17/100/The Competitive Acquisition Program (CAP) for Drugs and Biologicals Not Paid on a Cost or Prospective Payment Basis

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 4233	Date: February 8, 2019	Change Request: 11084

SUBJECT: Update to Publication (Pub.) 100-04 Chapters 4 and 17 to Provide Language-Only Changes for the New Medicare Card Project

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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 4 and chapter 17.

B. Policy: The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires removal of the 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 MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11084.1	Medicare Administrative Contractors (MACs) shall be aware of the updated language for the New Medicare Card Project in Pub. 100-04, chapter 4 and chapter 17.	X	X	X	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): Tracey Mackey, 410-786-5736 or Tracey.Mackey@cms.hhs.gov , Kim 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 4 - Part B Hospital
(Including Inpatient Hospital Part B and OPPS)

10.7.2.4 - Procedures for Medicare Contractors to Perform and Record Outlier Reconciliation Adjustments

(Rev.4233, Issued: 02-08-19, Effective: 03-12-19, Implementation: 03-12-19)

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 following is a step-by-step explanation of the procedures that Medicare contractors are to follow if a hospital (or CMHC) is eligible for outlier reconciliation:

1) The Medicare contractor sends notification to the CMS Central Office (not the hospital or CMHC), via the street address and email address provided in §10.11.3.1 and to the CMS Regional Office that a hospital or CMHC has met the criteria for OPPS outlier reconciliation. Medicare contractors shall include in their notification the provider number, provider name, cost reporting begin date, cost reporting end date, total outlier payments in the cost reporting period, the CCR or weighted average CCR from the time the claims were paid during the cost reporting period eligible for reconciliation and the final settled CCR.

2) If the Medicare contractor receives approval from the CMS Central Office and Regional Office that OPPS outlier reconciliation is appropriate, the Medicare contractor follows steps 3-14 below. **NOTE**: Hospital and CMHC cost reports will remain open until their claims have been processed for OPPS outlier reconciliation.

3) The Medicare contractor shall notify the hospital or CMHC and copy the CMS Regional Office and Central Office in writing and via email (through the address provided in §10.11.3.1) that the hospital or CMHC's OPPS outlier claims are to be reconciled.

4) Prior to running claims in the FISS Lump Sum Utility*, Medicare contractors shall update the applicable provider record in the Outpatient Provider Specific File (OPSF) by entering the final settled CCR from the cost report in Outpatient Cost to Charge Ratio field. No other elements in the OPSF shall be updated for the applicable provider records in the PSF that span the cost reporting period being reconciled aside from the CCR.

   *__NOTE__: The FISS Lump Sum Utility is a Medicare contractor tool that, depending on the elements that are input, will produce an extract that will calculate the difference between the original PPS payment amounts and revised PPS payment amounts into a Microsoft Access generated report. The Lump Sum Utility calculates the original and revised payments offline and will not affect the original claim payment amounts as displayed in various CMS systems (such as NCH).

5) Medicare contractors shall ensure that, prior to running claims through the FISS Lump Sum Utility, all pending claims (e.g., appeal adjustments) are finalized for the applicable provider.

6) Medicare contractors shall only run claims in the Lump Sum Utility that meet the following criteria:

- TOB 12X, 13X, 34X, 75X, 76X or any TOB with a condition code 07
- Claim has a line item date of service of January 1, 2009 or later that also contains a Pay Method Flag of '0'
- Previous claim is in a paid status (P location) within FISS
- Cancel date is 'blank'

7) The Medicare contractor reconciles the claims through the OPPS Pricer software and not through any editing or grouping software.

8) Upon completing steps 3 through 7 above, the Medicare contractor shall run the claims through the Lump Sum Utility. The Lump Sum Utility will produce an extract, according to the elements in Table 1 below. **NOTE**: The extract must be importable by Microsoft Access or a similar software program (Microsoft Excel).

9) Medicare contractors shall upload the extract into Microsoft Access or a similar software program to generate a report that contains elements in Table 1. Medicare contractors shall ensure this report is retained with the cost report settlement work papers.

10) For hospitals paid under the OPPS, the Lump Sum Utility will calculate the difference between the original outlier amount (value code 17) and the revised outlier amount (value code 17). If the difference between the original and revised outlier amount is positive, then a credit amount (addition) shall be issued to the provider. If the difference between the original and revised outlier amount is negative, then a debit amount (deduction) shall be issued to the provider.

11) Medicare contractors shall determine the applicable time value of money amount by using the calculation methodology in §10.7.2.3. If the difference between the original and revised outlier amount (calculated by the Lump Sum Utility) is a negative amount then the time value of money is also a negative amount. If the difference between the original and revised outlier amount (calculated by the Lump Sum Utility) is a positive amount then the time value of money is also a positive amount. Similar to step 10, if the time value of money is positive, then a credit amount (addition) shall be issued to the provider. If the time value of money is negative, then a debit amount (deduction) shall be issued to the provider. **NOTE**: The time value of money is applied to the difference between the original outlier amount (value code 17) and the revised outlier amount (value code 17).

12) For cost reporting periods beginning before May 1, 2010, under cost report 2552-96, the Medicare contractor shall record the original outlier amount from Worksheet E, Part B, line 1.02 (prior to the inclusion of line 54 of Worksheet E, Part B), the outlier reconciliation adjustment amount (the difference between the original and revised outlier amount (calculated by the Lump Sum Utility), the total time value of money, the rate used to calculate the time value of money and the sum of lines 51 and 53 on lines 50-54, of Worksheet E, Part B of the cost report (**NOTE**: the amounts recorded on lines 50, 51, 53 and 54 can be positive or negative amounts per the instructions above). The total outlier reconciliation amount (Worksheet E, Part B, line 54) shall be included on Worksheet E, Part B, line 1.02. For complete instructions on how to fill out these lines see §3630.2 of the Provider Reimbursement Manual, Part II.

For cost reporting periods beginning on or after May 1, 2010, under cost report 2552-10, the Medicare contractor shall record the original outlier amount from Worksheet E, Part B, line 4 (prior to the inclusion of line 94 of Worksheet E, Part B), the outlier reconciliation adjustment amount (the difference between the original and revised outlier amount (calculated by the Lump Sum Utility), the total time value of money, the rate used to calculate the time value of money and the sum of lines 91 and 93 on lines 90-94, of Worksheet E, Part B of the cost report (**NOTE**: the amounts recorded on lines 90, 91, 93 and 94 can be positive or negative amounts per the instructions above). The total outlier reconciliation amount (Worksheet E, Part B, line 94) shall be included on Worksheet E, Part B, line 1.02.

13) The Medicare contractor shall finalize the cost report, issue a NPR and make the necessary adjustment from or to the provider.

14) After determining the total outlier reconciliation amount and issuing a NPR, Medicare contractors shall restore the CCR(s) elements to their original values (that is, the CCRs used to pay the claims) in the applicable provider records in the PSF to ensure an accurate history is maintained. Specifically, for hospitals paid under the OPPS, Medicare contractors shall enter the original CCR in PSF field 25 -Operating Cost to Charge Ratio.

Medicare contractors shall contact the CMS Central Office via the address and email address provided in §10.11.3.1 with any questions regarding this process.

Table 1: Data Elements for FISS Extract

List of Data Elements for FISS Extract
Provider #
Medicare beneficiary identifier
Document Control Number (DCN)
Type of Bill
Original Paid Date
Statement From Date
Statement To Date
Original Reimbursement Amount (claims page 10)
Revised Reimbursement Amount (claim page 10)
Difference between these amounts
Original Deductible Amount, Payer A, B, C (Value Code A1, B1, C1)
Revised Deductible Amount, Payer A, B, C (Value Code A1, B1, C1)
Difference between these amounts
Original Coinsurance Amount, Payer A, B, C (Value Code A2, B2, C2)
Revised Coinsurance Amount, Payer A, B, C (Value Code A2, B2, C2)
Difference between these amounts
Original Outlier Amount (Value Code 17)
Revised Outlier Amount (Value Code 17)
Difference between these amounts
Original DSH Amount (Value Code 18)
Revised DSH Amount (Value Code 18)
Difference between these amounts
Original IME Amount (Value Code 19)
Revised IME Amount (Value Code 19)
Difference between these amounts
Original New Tech Add-on (Value Code 77)
Revised New Tech Add-on (Value Code 77)
Difference between these amounts

List of Data Elements for FISS Extract
Original Device Reductions (Value Code D4)
Revised Device Reductions (Value Code D4)
Difference between these amounts
Original Hospital Portion (claim page 14)
Revised Hospital Portion (claim page 14)
Difference between these amounts
Original Federal Portion (claim page 14)
Revised Federal Portion (claim page 14)
Difference between these amounts
Original C TOT PAY (claim page 14)
Revised C TOT PAY (claim page 14)
Difference between these amounts
Original C FSP (claim page 14)
Revised C FSP (claim page 14)
Difference between these amounts
Original C OUTLIER (claim page 14)
Revised C OUTLIER (claim page 14)
Difference between these amounts
Original C DSH ADJ (claim page 14)
Revised C DSH ADJ (claim page 14)
Difference between these amounts
Original C IME ADJ (claim page 14)
Revised C IME ADJ (claim page 14)
Difference between these amounts
Original Pricer Amount
Revised Pricer Amount
Difference between these amounts
Original PPS Payment (claim page 14)
Revised PPS Payment (claim page 14)
Difference between these amounts
Original PPS Return Code (claim page 14)
Revised PPS Return Code (claim page 14)
DRG
MSP Indicator (Value Codes 12-16 & 41-43 - indicator indicating the claim is MSP; 'Y' = MSP, 'blank' = no MSP
Reason Code
HMO-IME Indicator
Filler

40.4.2 - Procedures for Paying Claims Without Passing through the IOCE

(Rev.4233, Issued: 02-08-19, Effective: 03-12-19, Implementation: 03-12-19)

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.

Before an outpatient claim may be paid without first going through the IOCE, the contractor shall obtain approval from CMS Central Office or the RO. In all instances involving payment outside the normal outpatient editing process, the contractor applies the following procedures:

- Contractors shall submit the claim overriding the IOCE using the appropriate field in FISS.

- Pay interest accrued through the date payment is made on clean claims. Do not pay any additional interest.

- Maintain a record of payment and implement controls to be sure that incorrect payment is not made, i.e., when the claim is paid without being subject to normal editing.

- Monitor IOCE software to determine when the impediment to processing is removed.

- Consider the claim processed for workload and expenditure reports when it is paid.

- Submit to the RO Consortium Contractor Manager (CCM) by the 20th of each month a monthly report of all outpatient claims paid without processing through the IOCE. The list of claims paid outside of the IOCE is to include the following information:

    - *Mbi*
    - DCN
    - TOB
    - DOS (From/Through)
    - Provider Number
    - MCE/OCE OVR (Claim/Line)
    - Reimbursement Amount
    - Receipt Date
    - Process Date
    - Paid Date

Also, include summary data for each edit code showing claim volume and payment. Any override approvals received and/or relevant JSM references should be annotated on the reports.

Medicare Claims Processing Manual
Chapter 17 - Drugs and Biologicals

100 - The Competitive Acquisition Program (CAP) for Drugs and Biologicals Not Paid on a Cost or Prospective Payment Basis
(Rev.4233, Issued: 02-08-19, Effective: 03-12-19, Implementation: 03-12-19)

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 303 (d) of the Medicare Prescription Improvement and Modernization Act (MMA) of 2003 requires the implementation of a competitive acquisition program (CAP) for Medicare Part B drugs and biologicals not paid on a cost or prospective payment system basis. Beginning with drugs administered on or after July 1, 2006, physicians will be given a choice between buying and billing these drugs under the average sales price (ASP) system, or obtaining these drugs from vendors selected in a competitive bidding process. For purposes of the CAP, the term "a physician" includes individuals defined under §1861(s) of the Social Security Act who are authorized to provide physician services under §1861(s) of the Act and who can, within their State's scope of practice, prescribe and order drugs covered under Medicare Part B.

For 2006, the first CAP year will run from July 1, 2006 through December 31, 2006. In subsequent years, it will run annually on a calendar year basis.

The Secretary may exclude drugs from the CAP if competitive pricing will not result in significant savings, or is likely to have an adverse impact on access to such drugs. The statute gives CMS the authority to select drugs, or categories of drugs, that will be included in the program, to establish geographic competitive acquisition areas, and to phase in these elements as appropriate.

A competition will be held every 3 years to award contracts to approved CAP vendors that will supply drugs and biologicals for the program. A 3-year contract will be awarded to qualified approved CAP vendors in each geographic area who have and maintain: 1) Sufficient means to acquire and deliver competitively biddable drugs within the specified contract area; 2) Arrangements in effect for shipping at least 5 days each week for the competitively biddable drugs under the contract and means to ship drugs in emergency situations; 3) Quality, service, financial performance, and solvency standards; and 4) A grievance and appeals process for dispute resolution. A vendor's contract may be terminated during the contract period if they do not abide by the terms of their contract with CMS. CMS will establish a single payment amount for each of the competitively bid drugs and areas, for this 3year cycle there will be one drug category and one geographic area. After CAP drug prices are determined and vendor contracts are awarded the information will be posted to a directory on the Medicare Web site.

Medicare physicians will be given an opportunity to elect to participate in the CAP on an annual basis. Physicians who elect to participate in CAP will continue to bill their local A/B MAC (B) for drug administration. Except where applicable State pharmacy law prohibits it, the CAP Participating Physicians will supply the following information to the approved CAP vendor at the time that a CAP drug order is placed: date of order, beneficiary name, address, and phone number, physician identifying information: name, practice location/shipping address, group practice information, NPI; drug name, strength, quantity ordered, dose, frequency/ instructions, anticipated date of administration, *Medicare beneficiary identifier*, supplementary insurance information (if applicable), Medicaid information (if applicable), additional patient information: date of birth, allergies, height/weight, and diagnosis if necessary. Claims for erythropoiesis stimulating agents (ESAs) must contain the most recent hematocrit or hemoglobin value. CAP drug claims

for any drugs furnished to an individual for the treatment of anemia shall be returned if the most recent laboratory values for hemoglobin or hematocrit are not reported on the claim per Medicare requirements.

The participating CAP physicians will receive all of their drugs from the approved CAP vendor for the drug categories they have selected, with only one exception. The exception will be for "furnish as written" situations where the participating CAP physician requires that, due to medical necessity, the beneficiary must have a specific drug, defined by its National Drug Code (NDC), for one of the HCPCS codes within the approved CAP vendor's drug list if that specific drug NDC is not available on the CAP drug list. The participating CAP physician may buy the drug, administer it to the beneficiary and bill Medicare using the ASP system. The local A/B MAC (B) will monitor drugs obtained using the "furnish as written" provision to ensure that the participating CAP physician is complying with Medicare payment rules.

The CAP will also allow a participating CAP physician to provide a drug to a Medicare beneficiary from his or her own stock and obtain the replacement drug from the approved CAP vendor when certain conditions are met. The A/B MAC (B) will monitor drugs ordered under the replacement provision to ensure that the participating CAP physician is complying with Medicare payment rules.

Approved CAP vendors must qualify for enrollment in Medicare as a supplier, and will be enrolled as a new provider specialty type. The approved CAP vendor's claims for the drugs will be submitted to one designated Medicare A/B MAC (B). The approved CAP vendor will bill the Medicare designated A/B MAC (B) for the drug and the beneficiary for any applicable coinsurance and deductible under the MMA, for CAP claims submitted after July 1, 2006 but before April 1, 2007, payment to the approved CAP vendor for the drug was conditioned on verification that the drug was administered to the Medicare beneficiary. Proof that the drug was administered was established by matching the participating CAP physician's claim for drug administration with the approved CAP vendor's claim for the drug in the Medicare claims processing system by means of a prescription number on both claims. When the claims matched in the claims processing system, the approved CAP vendor was paid in full.

Title II, section 108(a) of the Tax Relief and Health Care Act of 2006 (TRHCA), struck language used to develop the existing CAP claims matching process and furthermore required the implementation of a post payment review process effective April 1, 2007. The post payment review process is required to assure that drugs supplied under the CAP have been administered to a beneficiary and the process must establish a mechanism to recoup, offset or collect any overpayments to the approved CAP vendor. The CMS is implementing CAP claims processing changes in order to comply with THRCA by April 1, 2007. Pending CAP claims submitted prior to April 1, 2007, and all new CAP claims submitted on or after April 1 will be subject to the post payment review process. Until drug administration is verified, the approved CAP vendor may not bill the beneficiary and/or his third party insurance for any applicable coinsurance and deductible. For more information on the CAP claims processing see FR70251.