CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2594	**Date: November 16, 2012**
	Change Request 8094

SUBJECT: Testing HIPAA Transactions Following a System Change

I. SUMMARY OF CHANGES: This Change Request instructs Shared System Maintainers and contractors to test/identify and develop resolution for any resulting Out of Balance (OOB) situation for ASC X12 Transaction 835 after implementing system change.

EFFECTIVE DATE: April 1, 2013
IMPLEMENTATION DATE: April 1, 2013

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	22/20/General Remittance Completion Requirements

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with 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 obliged 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: 2594	Date: November 16, 2012	Change Request: 8094

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EFFECTIVE DATE: April 1, 2013
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I. GENERAL INFORMATION

A. Background: It has been reported to the Centers for Medicare and Medicaid Services (CMS) that under some situations as a result of a system change related to a policy change that may or may not be directly related to Electronic Data Interchange (EDI) or ASC X12 Transaction 835 in particular, the required balancing of Health Insurance Portability and Accountability Act (HIPAA) covered Transaction 835 does not work. This Change Request (CR) instructs the Shared System Maintainers (SSMs) and the contractors to complete testing and/or identification of the root cause and develop a resolution to make sure that the HIPAA transaction 835 - Remittance Advice balance per ASC X12 TR3s after a system change has been implemented.

B. Policy: CMS generates HIPAA compliant transactions including ASC X12 835.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement.

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
8094.1	MCS and VMS shall identify any issue during testing and research and develop resolution to make sure that the ASC X12 Transactions 835 balances after a system change. **NOTE:** The Shared Systems shall continue generating the OOB reports that are currently being generated.								X			
8094.1.1	STC shall identify any issue during testing to make sure that the ASC X12 Transactions 835 balances after a system change.											STC
8094.2	Contractors shall monitor Out of Balance (OOB) reports for 835's in their UAT/Testing environment during release (quarterly and off-quarterly) testing and contact/work with the related Shared System Maintainer to resolve issues that are resulting in OOB situations for Transaction 835.	X	X	X	X	X	X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility						
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Other
		Part A	Part B					
	None							

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A
Use "Should" to denote 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): Sumita Sen, sumita.sen@cms.hhs.gov

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

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

Section B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS do 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.

20 - General Remittance Completion Requirements

(Rev. 2594, Issued: 11-16-12, Effective: 04-01-13, Implementation: 04-01-13

The following general field completion and calculation rules apply to both paper and electronic versions of the remittance advice, except as otherwise noted. See the current implementation guide for specific requirements:

- Any adjustment applied to the submitted charge and/or units must be reported in the claim and/or service adjustment segments with the appropriate group, reason, and remark codes explaining the adjustments. Every provider level adjustment must likewise be reported in the provider level adjustment section of the remittance advice. Intermediary (A/B MAC /FI/RHHI) RAs do not report service line adjustment data, only summary claim level adjustment information is reported.

- The computed field “Net” reported in the Standard Paper Remittance (SPR) notice must include “ProvPd” (Calculated Pmt to Provider, CLP04 in the 835) and interest, late filing charges and previously paid amounts.

- The Medicare contractors report only one crossover payer name on both the ERA and SPR, even if coordination of benefits (COB) information is sent to more than one payer. The current HIPAA compliant version of 835 does not have the capacity to report more than one crossover carrier, and the SPR mirrors the 835.

- The check amount is the sum of all claim-level payments, including claims and service-level adjustments, less any provider level adjustments.

- Positive adjustment amounts reduce the amount of the payment and negative adjustment amounts increase it.

- The contractor does not issue an RA for a voided or cancelled claim. It issues an RA for the adjusted claim with “Previously Paid” (CLP04 in the 835) showing the amount paid for the voided claim."

- *The shared system maintainers and contractor must make sure that the HIPAA transactions 835 and 837 COB balance after a system change resulting from a policy change that may or may not be directly related to Electronic Data Interchange (EDI).*