CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 13041	**Date: January 10, 2025**
	Change Request 13900

SUBJECT: Editing for Duplicate Processing for Practitioner Professional Services and Critical Access Hospital (CAH) Professional Services

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to prevent duplicate billing of professional claims from CAHs and professional physicians that were identified in Office of Inspector General (OIG) Report: Duplicate Medicare Professional Fee Billing by Both the Critical Access Hospital (CAH) and Health Care Practitioner to Medicare Part B (A-06-21-05003).

EFFECTIVE DATE: July 1, 2025
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 7, 2025

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

Pub. 100-20	Transmittal: 13041	Date: January 10, 2025	Change Request: 13900

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I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to prevent duplicate billing of professional claims from CAHs and professional physicians that were identified in Office of Inspector General (OIG) Report: Duplicate Medicare Professional Fee Billing by Both the Critical Access Hospital (CAH) and Health Care Practitioner to Medicare Part B (A-06-21-05003).

II. GENERAL INFORMATION

A. Background:

The purpose of this Change Request (CR) is to detect and prevent duplicate billing of professional claims from CAHs and physicians with the same date of service, beneficiary, and procedure information. Overpayments have occurred because Medicare claims' systems have not been programmed to detect when a CAH submits a claim for reimbursement for professional services when the physician has reassigned their billing rights or when providers submit a claim for reimbursement when they have reassigned their billing rights to the CAH.

An OIG audit (A-06-21-05003) was conducted. It was determined there was inconsistent billing from CAHs and physicians resulting in unnecessary overpayments. The audit results found that CAHs were paid for professional services by provided health care practitioners that received payment for the same services provided at the CAH. The audit also found that health care practitioners were billing for services after they reassigned their billing rights to the CAH. Both scenarios have resulted in duplicate reimbursements for the same services provided at the CAH.

Due to the findings of the OIG audit, CMS researched the process to determine the best approach for the detection and prevention of duplicate payments for professional claims from CAHs and health care professionals. This CR will enhance systems' edits to detect and prevent duplicate payments for CAHs and health care professionals.

B. Policy: N/A

III. 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	
13900.1	The Contractors shall accept the PECOS extract file with the following criteria: 1. Record Type 2. FI Contractor ID 3. Create Date 4. PAC ID of the CAH 5. Enrollment ID of the CAH 6. SSN of the Individual reassigning benefits to CAH 7. Practitioner Name Members 8. PAC ID of the Individual 9. Enrollment ID of the Individual 10. Effective Date of the Reassignment 11. End Date of the Reassignment 12. NPI Identification Number of the Individual NOTE: Child record 20-Attachment 1					X				PECOS
13900.1.1	PECOS shall perform a one-time trigger for all the current CAH enrollments with Reassignments to FISS after the changes are deployed to PROD.									Hybrid Cloud Data Center (HCDC), MIST, PECOS
13900.1.2	The Contractor shall accept the PECOS nightly file of only physicians who are newly added to PECOS or who were on the initial or earlier nightly files and who have a change of information.					X				PECOS
13900.1.3	The contractor shall create a new interface screen to store physician reassigned benefits					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	information to the CAH from the PECOS extract file. The following fields will be added to the new screen. • EFFECTIVE – This field will store the date from the REASGNMT_EFCTV_DT field sent on the PECOS Child Record 20. • END DATE – This field will store the date from the REASGNMT_END_DT field sent on the PECOS Child Record 20 if available. • NPI – This field will store the NPI from the REASGMNT_NPI field sent on the PECOS Child Record 20. • LAST NAME – This field will store the Physician's Last Name from the LAST_NAME field sent on the PECOS Child Record 20. • FIRST NAME – This field will store the Physician's First Name from the FIRST_NAME field sent on the PECOS Child Record 20. • MIDDLE NAME – This field will store the Physician's Middle Name from the MDL_NAME field on the PECOS Child Record 20. • CCN – This field will store the CCN of the									

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	CAH from Child Record 2. See the Child Record 20 Layout									
13900.1.4	The Contractor shall ensure that information housed in the fields from BR 13900.1.3 on the newly created screen be populated only by the PECOS system interface and shall be locked from manual data entry.					X				PECOS
13900.1.5	The Contractor shall create a new report to display all PECOS updates made on the new interface screen.					X				
13900.2	The Contractor shall continue to apply the current line level editing for TOB 85X, revenue codes 096X, 097X and 098X; based on the following hierarchy: • Line Level "Rendering Physician" field when populated, or • Claim level “Rendering Physician" field where a line level "Rendering Provider" field is blank, or • Claim level "Attending Physician” field if the claim level “Rendering Provider" field is blank. • NOTE: Blank NPI line level information indicates the claim level attending or rendering					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	provider performed the services.									
13900.3	The Contractor shall create a new overridable Line Level Reason code to assign on CAH Method II TOB 85X on claim lines with Revenue Code 096X, 097X and/or 098X when: • The Attending Physician NPI is not associated with the CAH Method II on the new PECOS reassigned benefits screen. OR • The Line Level Date of Service on the claim does not fall within the Effective and Term dates of reassignment to the CAH Method II for the "Attending Physician" on the new PECOS reassigned benefits screen.					X				
13900.3.1	The Contractors shall deny the lines and use the following messages: CARC 16 - Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. RARC N253. – Missing/incomplete/invalid attending provider primary identifier.	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Group code - CO MSN 9.4 - This item or service was denied because information required to make payment was incorrect.									
13900.4	The Contractor shall create a new overridable Line Level Reason code to assign on CAH Method II TOB 85X on claim lines with Revenue Code 096X, 097X and/or 098X when: • The Rendering Physician NPI is not associated with the CAH Method II on the new PECOS reassigned benefits screen. OR • The Line Level Date of Service on the claim does not fall within the Effective and End dates of reassignment to the CAH Method II for the "Rendering Physician" on the new PECOS reassigned benefits screen.					X				
13900.4.1	The Contractors shall deny the lines and use the following messages: CARC 16 - Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. RARC N290 - Missing/incomplete/invalid	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	rendering provider primary identifier. Group code - CO MSN 9.4 - This item or service was denied because information required to make payment was incorrect.									
13900.5	The Contractors shall update their Revenue Code table to require a HCPCS code to be present on TOB 85X, with Revenue codes 096X, 097X or 098X.	X								
13900.6	The Contractor shall create new ABX edit XXXX that will set on an incoming Part B claim against a history HUOP claim (TOB 85X, with revenue code 96X, 97X, or 98X for CAH Method II billing) for duplicate professional services. A duplicate service will be defined to set the edit as follows: Incoming Part B claim data will match all the following on the history Outpatient CAH claim: • Detail Line-Item Date of Service (DLIDOS) must equal the detail line(s) DOS of the CAH claim • Procedure code must equal the procedure code billed on the CAH claim detail line. • Rendering NPI must equal the Rendering NPI on								X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	the CAH claim detail line (or header of the claim, if no NPI is present on the detail line).									
13900.6.1	The Contractor shall reject the new ABX edit at the detail line.								X	
13900.6.2	The Contractor shall make the new ABX edit overridable at the detail line.								X	
13900.6.3	The Contractor shall return trailers 08, 13 and 39 for the new ABX edit.								X	
13900.7	For claims returned with the trailers identified in the previous BR, contractors shall deny the detail line on the professional claims.		X							
13900.7.1	The Contractors shall use the following messages: CARC 97 - The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. RARC N472 - Payment for this service has been issued to another provider. Group Code – CO MSN 7.1: This is a duplicate of a charge already submitted. Spanish language translation:		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Este es un duplicado de un cargo previamente sometido.									
13900.8	The Contractor shall create a new IUR to generate on a history Part B professional claim for duplicate services that are also billed on the incoming outpatient CAH Method II provider claim (TOB 85X, with revenue code 96X, 97X, or 98X for CAH Method II billing). **NOTE**: The incoming outpatient claim must be billed on TOB 85X, with revenue codes 96X, 97X, and/or 98X to indicate CAH Method II billing of professional services. If the outpatient claim does not meet these conditions, the new IUR will not generate on the Part B claim. A duplicate service will be defined to generate the IUR as follows: Incoming Outpatient CAH claim data will match all the following on the history Part B claim: • Detail Line-Item Date of Service (DLIDOS) must equal the DLIDOS of the Part B claim • Procedure code must equal the procedure code billed on the Part B claim detail line.								X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• Rendering NPI must equal the Rendering NPI on the Part B claim detail line (or header of the claim, if no NPI is present on the detail line).									
13900.8.1	The Contractor shall not set the edit IUR on the professional claim in history when the impacted history detail line has the edit override present.								X	
13900.8.2	The Contractor shall return trailer 24 for the new IUR edit.								X	
13900.9	The Contractor shall create an adjustment based on the IUR.						X			
13900.9.1	The Contractors shall use the following messages: CARC 97 - The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. RARC N472 - Payment for this service has been issued to another provider. Group Code – CO MSN 7.1: This is a duplicate of a charge already submitted. Spanish language translation: Este es un duplicado de un		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	cargo previamente sometido.									
13900.10	PECOS shall send any new CAH reassignments in Child Record 20 to FISS. Note: See attachment 1 for the layout.					X				Hybrid Cloud Data Center (HCDC), PECOS
13900.11	The Contractor shall send a test file to FISS by 03/08/2025 for unit testing. This will allow FISS to test the acceptance of Child Record 20 and to determine any file issues early on during the software development phase. In addition, a test file will be sent to the MIST by 05/12/2025 and a test file sent to HCDCs for UAT testing on 6/07/2025.					X				Hybrid Cloud Data Center (HCDC), MIST, PECOS
13900.12	The Contractors shall attend calls as needed with PECOS and FISS to determine any file issues early in the SDLC near the end of March 2025. Note: At least 4 months prior to release.	X				X				Hybrid Cloud Data Center (HCDC), PECOS
13900.12.1	The Contractors shall provide the list of participant names and email addresses by day one of the Program Implement (PI) Planning or sooner, to Cindy Pitts@cms.hhs.gov.	X				X				Hybrid Cloud Data Center (HCDC), PECOS
13900.13	PECOS shall send the production file to the HCDCs by 07/07/2025. This file will be sent in place of the daily extract file. PECOS will notify the HCDCs prior to sending the file.									Hybrid Cloud Data Center (HCDC), PECOS

IV. PROVIDER EDUCATION

None

Impacted Contractors: None

V. 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

VI. CONTACTS

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

VII. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
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ATTACHMENTS: 1

FISS Child Record 20 for Individual Reassignment Information:

Description	Field Name	Length	Default Value	Start Position	PECOS DM Table	PECOS DM Field
SSN	SSN-MEMBERS	9	N/A	41	ODS_SGNTR	SSN
Name	PRACTITIONER-NAME-MEMBERS	85	N/A	50	ODS_SGNTR	FIRST_NAME, MDL_NAME, LAST_NAME
PAC ID	PROVIDER-PAC-ID-MEMBERS	10	N/A	135	ODS_ENRLMT_REASGNMT	PECOS_ASCT_CNTL_ID
Enrollment ID	ENROLLMENT-ID-MEMBERS	15	N/A	145	ODS_ENRLMT_REASGNMT	PRCTNR_ENRLMT_ID
Effective Date	EFFECTIVE-DATE-MEMBERS	8	N/A	160	ODS_ENRLMT_REASGNMT	REASGNMT_EFCTV_DT
End Date	END-DATE-MEMBERS	8	N/A	168	ODS_ENRLMT_REASGNMT	REASGNMT_END_DT
NPI Identification Number *	REASGNMT-NPI	10	N/A	176	ODS_ENRLMT_REASGNMT	REASGNMT_NPI
Filler	FILLER	636	N/A	186	N/A	N/A
Total Length	N/A	**821**	N/A	N/A	N/A	N/A

Complete layout for Child Record 20.

Description	Field Name	Length	Default Value	Start Position	PECOS DM Table	PECOS DM Field
Record Type	BSE-REC-TYPE	2	00	1	N/A	N/A
FI Contractor ID	BSE-FI-ID	5	N/A	3	ODS_LORV	CNTRCTR_ID
Create Date	BSE-CREAT-DT	8	N/A	8	ODS_ENRLMT_INFO	CREAT_TS

Description	Field Name	Length	Default Value	Start Position	PECOS DM Table	PECOS DM Field
PAC ID	BSE-PAC-ID	10	N/A	16	ODS_ENRLMT_INFO	PECOS_ASCT_CNTL_ID
Enrollment ID	BSE-ENR-ID	15	N/A	26	ODS_ENRLMT_INFO	ENRLMT_ID
SSN	SSN-MEMBERS	9	N/A	41	ODS_SGNTR	SSN
Name	PRACTITIONER-NAME-MEMBERS	85	N/A	50	ODS_SGNTR	FIRST_NAME, MDL_NAME, LAST_NAME
PAC ID	PROVIDER-PAC-ID-MEMBERS	10	N/A	135	ODS_ENRLMT_REASGNMT	PECOS_ASCT_CNTL_ID
Enrollment ID	ENROLLMENT-ID-MEMBERS	15	N/A	145	ODS_ENRLMT_REASGNMT	PRCTNR_ENRLMT_ID
Effective Date	EFFECTIVE-DATE-MEMBERS	8	N/A	160	ODS_ENRLMT_REASGNMT	REASGNMT_EFCTV_DT
End Date	END-DATE-MEMBERS	8	N/A	168	ODS_ENRLMT_REASGNMT	REASGNMT_END_DT
NPI Identification Number *	REASGNMT-NPI	10	N/A	176	ODS_ENRLMT_REASGNMT	REASGNMT_NPI
Filler	FILLER	636	N/A	186	N/A	N/A
Total Length	N/A	**821**	N/A	N/A	N/A	N/A