DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

REVISED product from the Medicare Learning Network® (MLN):

- "General Equivalence Mappings Frequently Asked Questions," Booklet, ICN 901743, hard copy only.

MLN Matters® Number: MM8297	Related Change Request (CR) #: CR 8297
Related CR Release Date: November 15, 2013	Effective Date: April 1, 2014
Related CR Transmittal #: R1318OTN	Implementation Date: April 7, 2014, except July 7, 2014, for suppliers billing DME MACs

Use of Claim Adjustment Reason Code 23

Provider Types Affected

This MLN Matters® Article is intended for physicians, Home Health Agencies (HHAs), and other providers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), Medicare Administrative Contractors (A/B MACs), or Durable Medical Equipment MACs (DME MACs)) for services to Medicare beneficiaries.

What You Need to Know

Change Request (CR) 8297, from which this article is taken, modifies Medicare claims processing systems to use Medicare Claim Adjustment Reason Codes (CARC) 23 to report impact of prior payers' adjudication on Medicare payment in the case of a secondary claim.

Background

Effective April 1, 2013, CR8154 – "Remittance Advice Remark and Claims Adjustment Reason Code, Medicare Remit Easy Print, and PC Print Update" modified CARC 23 (The impact of prior payer(s) adjudication including payments and/or adjustments (Use only with Group Code OA)); to include the

instruction that it must be used with Group Code OA (Other Adjustment). The Centers for Medicare & Medicaid Services (CMS) has become aware that the modification to this CARC has resulted in some issues for Medicare. (You can find the MLN Matters article associated with CR8154 at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8154.pdf on the CMS website.)

CR8297, from which this article is taken, instructs the Medicare's Shared System Maintainers (SSMs) on how to use CARC 23 to report prior payers' adjudication in the case of a secondary claim.

Medicare beneficiaries may have multiple coverages that occur either before or after Medicare. If (per Coordination Of Benefits) Medicare is the secondary payer, the adjudication process has to take into consideration how previous payers have adjudicated the claim, and report accordingly on the Remittance Advice (RA). The implementation guide for the current Electronic Remittance Advice (ERA) - ASC X12 Transaction 835 version 5010 - has explicit instruction in the Front Matter, Section 1.10.2.13 (Secondary Payment Reporting Consideration) to:

> "Report the "impact" in the appropriate claim or service level CAS segment with reason code 23 (Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments); and Claim Adjustment Group Code OA (Other Adjustment). Code OA is used to identify this as an administrative adjustment.……It is essential that any secondary payer report in the remittance advice only the primary amount that has actually impacted their secondary payment. In many cases, this "impact" is less than the actual primary payment." In these instances, reporting the actual payment would prevent the transaction from balancing.

Medicare does not have to report everything a previous payer has done, because that information is reported by that payer to the provider through the previous payer's Remittance Advice (RA). In order to generate and send a balanced Medicare RA and Coordination of Benefits (COB) Claim, Medicare should report only the part of previous payers' adjudication that impacts Medicare calculation of payment and adjustments.

Specifically, CR8297 requires the Medicare SSMs to report:

1. The Medicare allowed amount in the appropriate claim or service level "AMT" segment using qualifier AU (claim level) or B6 (service level) in AMT01 (Actual Amount Qualifier Code);
2. Any patient responsibility, remaining after coordination of benefits with the previous payer(s), with Group Code "PR" (Patient Responsibility) and the appropriate Claim Adjustment Reason Code (for example: 1 - Deductible Amount, 2 - Coinsurance Amount); and
3. Any further adjustment, taken by Medicare as a result of previous payer(s) payment and/or adjustment(s), with Group Code OA and Claim Adjustment Reason Code 23.

Additional Information

The official instruction, CR8297 issued to your MAC regarding this change is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1318OTN.pdf on the CMS website.

If you have any questions, please contact your MAC at their toll-free number, which may be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.

News Flash - Generally, Medicare Part B covers one flu vaccination and its administration per flu season for beneficiaries without co-pay or deductible. Now is the perfect time to vaccinate beneficiaries. Health care providers are encouraged to get a flu vaccine to help protect themselves from the flu and to keep from spreading it to their family, co-workers, and patients. Note: The flu vaccine is not a Part D-covered drug. For more information, visit:

- MLN Matters® Article #MM8433, "Influenza Vaccine Payment Allowances - Annual Update for 2013-2014 Season"
- MLN Matters® Article #SE1336, "2013-2014 Influenza (Flu) Resources for Health Care Professionals"
- HealthMap Vaccine Finder - a free, online service where users can search for locations offering flu and other adult vaccines. While some providers may offer flu vaccines, those that don't can help their patients locate flu vaccines within their local community.

The CDC website for Free Resources, including prescription-style tear-pads that allow you to give a customized flu shot reminder to patients at high-risk for complications from the flu.