CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10229	**Date: July 21, 2020**
	Change Request 11580

Transmittal 10071, dated May 1, 2020, is being rescinded and replaced by Transmittal 10229, dated, July 21, 2020 to revise business requirement 11580.3.2. All other information remains the same.

SUBJECT: Modify Edits in the Fee for Service (FFS) System When a Beneficiary has a Medicare Advantage (MA) Plan

I. SUMMARY OF CHANGES: The purpose of this change request (CR) is to modify edits that assign on inpatient claims when a beneficiary's MA plan becomes effective during the inpatient admission. In addition, we are modifying FFS edits that assign on claims for services that are not included in the MA capitation rate.

EFFECTIVE DATE: October 1, 2020 - For claims received on or after October 1, 2020
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 5, 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	32/66/66/National Coverage Determination (NCDs) services that are considered a significant cost for Medicare Advantage
N	32/66/66.1/Institutional Billing for National Coverage Determination (NCDs) services that are considered a significant cost for Medicare Advantage
N	32/66/66.2/Services Identified as having Significant Cost for Medicare Advantage

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
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 10229	Date: July 21, 2020	Change Request: 11580

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SUBJECT: Modify Edits in the Fee for Service (FFS) System When a Beneficiary has a Medicare Advantage (MA) Plan

EFFECTIVE DATE: October 1, 2020 - For claims received on or after October 1, 2020
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I. GENERAL INFORMATION

A. Background: When a Medicare beneficiary enrolls in a Medicare Advantage (MA) plan, the MA benefits replace traditional Medicare Fee for Service (FFS) claims payment. For inpatient claims (hospital paid under a prospective payment system), Medicare policy dictates that the payer at the time of admission will continue to be responsible for any inpatient stay when a beneficiary enrolls or dis-enrolls from an MA plan after the admission date and prior to the hospital discharge. When a beneficiary is admitted as an inpatient and does not have Part A hospital benefits remaining or benefits exhaust during the stay, Medicare allows the provider to submit a claim for ancillary services that are payable under Part B on type of bill (TOB) 012X. The beneficiary is still classified as an inpatient even though no Medicare Part A benefits are payable (reg)(42 CFR§422.318.b.1).

The Centers for Medicare & Medicaid Services (CMS) is aware of an issue where the Common Working File (CWF) is incorrectly rejecting TOB 012X when the beneficiary enrollment in an MA plan was effective after the admission date on the claim. This issue is also impacting providers who submit claims for flu vaccines provided to inpatient beneficiaries during a Medicare Part A covered stay. Effective October 1, 2016, Medicare will reimburse a Skilled Nursing Facility (SNF) or hospital facility for a flu vaccine provided during an inpatient stay. The Medicare Internet Only Manual (IOM) requires the facility to submit the vaccine on an ancillary claim using the discharge date as the statement covers from and through date.

In addition, CMS is streamlining the editing for MA plans' claims when it is determined that certain services are being disallowed on MA plans that are considered a significant cost under section 422.109(a)(2) of title 42 of the Code of Federal Regulations. Traditional Medicare FFS will pay for services obtained by beneficiaries enrolled in Medicare Advantage (MA) plans in this circumstance.

Consistent with §1862 (t)(2) of the Social Security Act, Medicare Administrative Contractors will pay for identified significant cost services for Medicare beneficiaries enrolled in MA plans.

B. Policy: N/A

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	
11580.1	The Medicare contractors shall look at the "admission" date, the "from" date and the "through" date on TOB 012x and if the admission date is prior to the MA effective date allow services under the Medicare FFS plan. Current editing is erroneously looking at the "from" date. Note: There will not be any changes for BDS. CWF will read the APC Indicator to determine if Admit Date or Dates of Service should be read for TOB 12x for MA Plan edit/IUR.								X	
11580.1.1	Medicare contractor shall bypass Medicare Advantage service for editing inpatient Part B services for TOB 012x (Hospital Ancillary) where Medicare is responsible for payment at the time of admission through discharge when the APC payment indicator is other than 2. Example: Beneficiary exhausted benefits Inpatient Date of service 01/05/19 – Discharge date 03/01/19, MA enrollment period effective date 02/01/19. Benefits exhausted on 02/10/19 and the remaining services were billed under TOB 012x. In the example, Medicare was primary at the admission; therefore, Medicare is responsible for the entire inpatient confinement including the 12x claim.								X	
11580.1.2	The Medicare Contractors shall continue to edit on incoming claims for MA coverage to assign on TOB 012x if the MA effective date is on or before the admission date, if the APC payment indicator is 2. If the admission date on the 12x claim is prior to the MA effective date and the APC payment indicator is 2, Medicare Contractors shall not edit on the incoming claim for MA coverage.								X	
11580.1.3	The Medicare contractor shall ensure that the HMO PAID IND is assigned correctly by FISS based on the CWF reply.					X				
11580.2	The Medicare contractors shall allow Condition Code (CC) 78 on any inpatient and outpatient institutional claims for Medicare Advantage beneficiaries when it is determined that certain services are being	X				X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	disallowed on MA plans that are considered a significant cost under section 422.109(a)(2) of title 42 of the Code of Federal Regulations. Any current editing that doesn't allow this shall be updated to allow this scenario, unless there has been previous instructions excluding certain conditions. Note: Condition Code 78 = Newly covered Medicare service for which an HMO doesn't pay.									
11580.3	The Medicare contractors shall create an A/B MAC controlled reusable solution to update which services are payable under FFS based on direction given by CMS for Medicare Advantage beneficiaries whose claims include a CC 78.	X				X				
11580.3.1	The Medicare contractors shall include the following information on the reusable solution when CC 78 is allowed to be billed per CMS instructions. CR/TDL number Effective Date Termination date And at least (1) of the following: Revenue Code(s), if applicable ICD-10 Diagnosis Code(s), if applicable ICD - 10 PCS Code(s) for inpatient claims, if applicable HCPCS Code(s) for outpatient claims, if applicable	X				X				
11580.3.2	The Medicare contractor shall create an overrideable reason code, if CC 78 is present and the following conditions are not met: • The applicable LIDOS for services paid under Part B claims or the through date for services paid under Part A claims are not within the effective through termination date period, and • The information on the claim does not match the identified required information in the reusable solution. Note: For services paid under Part A, claims would match any Revenue Code, ICD-10 Diagnosis Code,					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	and ICD-10 PCS code listed; for services paid under Part B, claims would need to match any Revenue Code, ICD-10 Diagnosis Code, and HCPCS Codes listed.									
11580.3.3	The contractor shall ensure that the newly created reason code is set to RTP.	X								
11580.3.4	CMS shall continue to issue direction to the MACs to allow for specific services under FFS per the current process. MACs shall update the reusable solution created in BR 11580.3 accordingly.	X								CMS
11580.4	When CC78 is present on an inpatient or outpatient claim as noted in BR 11580.3, the Medicare contractor shall perform the following: Modify to reset the HMO pay code to "0". Set Expense Subject to the Deductible to zero. Append Payer Only CC: MA, on outpatient bill types. Note: MA=Managed Care Enrollee					X				
11580.5	The Medicare contractor shall ensure that current editing is adjusted to allow CC 78 on Medicare Advantage beneficiary claims that are required to be paid by FFS Medicare for the reusable solution in BR 11580.3.1.					X			X	
11580.6	The Medicare contractor shall remove existing logic criteria to no longer set MA edits/IURs for CC 78 on institutional MA claims. NOTE: In addition, to modifying edit 2216.								X	

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
11580.7	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				

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): Fred Rooke, Fred.Rooke@cms.hhs.gov , Cindy Pitts, Cindy.Pitts@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 32 – Billing Requirements for Special Services

Table of Contents
(Rev. 10229; Issued 07-21-20)

66 - National Coverage Determination (NCDs) services that are considered a significant cost for Medicare Advantage Plans

(Rev. 10229, Issued: 07-21-20 Effective: 10-01-20, Implementation: 10-05-20)

CMS is streamlining the editing for MA plans' claims when it is determined that certain services are being disallowed on MA plans that are considered a significant cost under section 422.109(a)(2) of title 42 of the Code of Federal Regulations. Original fee-for-service Medicare will pay for services obtained by beneficiaries enrolled in Medicare Advantage (MA) plans in this circumstance.

Consistent with §1862 (t)(2) of the Social Security Act, Medicare Administrative Contractors will pay for identified significant cost services for Medicare beneficiaries enrolled in MA plans. In addition 42 CFR §422.109, the Medicare payment for the services or benefit is made directly by the A/B MAC to the provider furnishing the service or benefit in accordance with original Medicare payment, rules, methods, and requirements.

Beneficiaries are liable for any applicable coinsurance amounts.
Cost for NCD services legislative changes in benefits for which CMS A/B MACs will not make payment and are the responsibility of the M+C organization are:

- *I. Services necessary to diagnose a condition covered by the NCD or legislative changes in benefits;*
- *II. Most services furnished as follow up care to the NCD services or legislative changes in benefits;*
- *III. Any services that is already a Medicare-covered service and included in the annual M+C capitation rate or previously, adjusted payments; and*
- *IV. Any services, including costs of the NCD service or legislative change in benefits, to the extent the M+C organization is already obligated to cover it as an additional benefit under 42CFR §422.312 or supplemental benefit under 42 CFR §422.102.*

66.1 – Institutional Billing for National Coverage Determination (NCDs) services that are considered a significant cost for Medicare Advantage

(Rev. 10229, Issued: 07-21-20 Effective: 10-01-20, Implementation: 10-05-20)

A. Institutional Inpatient Billing for National Coverage Determination (NCDs) services that are considered a significant cost for Medicare Advantage.

The Medicare contractors shall allow Condition Code (CC) 78 on any inpatient institutional claims for Medicare Advantage beneficiaries when it is determined that certain services are being disallowed on MA plans that are considered a significant cost under section 422.109(a)(2) of title 42 of the Code of Federal Regulations. Any current editing that doesn't allow this shall be updated to allow this scenario, unless there has been previous instructions excluding certain conditions.

***Note:** Condition Code 78 = Newly covered Medicare service for which an HMO doesn't pay*

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B. Institutional Outpatient Billing for National Coverage Determination (NCDs) services that are considered a significant cost for Medicare Advantage

The Medicare contractors shall allow Condition Code (CC) 78 on any outpatient institutional claims for Medicare Advantage beneficiaries when it is determined that certain services are being disallowed on MA plans that are considered a significant cost under section 422.109(a)(2) of title 42 of the Code of Federal Regulations. Any current editing that doesn't allow this shall be updated to allow this scenario, unless there has been previous instructions excluding certain conditions.

***Note:** Condition Code 78 = Newly covered Medicare service for which an HMO doesn't pay.*

66.2 – Services Identified as having Significant Cost for Medicare Advantage

(Rev. 10229, Issued: 07-21-20 Effective: 10-01-20, Implementation: 10-05-20)

Services Identified as having Significant cost under section 422.109(a)(2) of title 42 of the Code of Federal Regulations Providers may bill the A/B MAC for these NCD services provided to a MA beneficiary.

Services Identified as having Significant cost					
Service/Benefit	*Revenue Code*	*HCPCS*	*ICD-10-PCS Procedure*	*Significant Cost Start*	*Significant Cost End*
CAR-T	*0891*	*Q2041, Q2042*	*XW033C3 or XW043C3*	*08/07/2019*	*12/31/2020*