PROVIDER QUICK TIPS

#177

Medicare Dual Eligible Claims with Duplicate CARC (Claim Adjustment Reason Code) CO 237

Medical Assistance (MA) confirmed in February and March of 2015 new practices undertaken by the Centers for Medicare and Medicaid Services (CMS) which caused MA to not accept defined crossover claims submitted directly from Medicare. Effective January 1, 2015, CMS began to represent, on claims submitted to MA, different provider payment reduction initiatives using the same group code and CARC combination at the claim detail level. More specifically, group code CO (Contractual Obligations) in combination with CARC 237 (Legislated/Regulatory Penalty) appeared in the Accredited Standards Committee (ASC) 837P X12 v.5010 CAS segment of Loop 2430 more than once for those providers subject to multiple Medicare payment reductions in relation to various CMS electronic health initiatives [e.g. e-Prescribing, Value-based payment modifier, Electronic Health Record (EHR) Incentive program, and Physician Quality Reporting System (PQRS)].

Note: CMS was using CO 237 prior to date of service January 1, 2015 for e-Prescribing only, but it was only after this date when CMS replaced e-Prescribing using CO 237 instead for three new initiatives: EHR, PQRS, and Value-based payment modifier.

Because this practice of using multiple entries of CO 237 in the same loop and CAS segment conflicts with ASC standard user guidelines, MA's ASC X12 v. 5010 rules caused direct crossover claims to be rejected and subsequently to not be processed by its claims management system, i.e. PROMISe™. As a result, MA providers may have experienced the loss of claims for dual eligible beneficiaries which had been successfully adjudicated by Medicare but had failed to crossover to MA as anticipated.

Upon confirmation of the issue described above and in light of the fact that CMS has communicated no plans to modify its usage of CARC CO 237, MA has taken steps to bypass the ASC X12 rule which had prevented providers' Medicare-submitted claims from successfully crossing over to MA. As of April 24, 2015, MA implemented the necessary change required to accept electronic claims directly submitted to MA from Medicare when the payer segment contained more than one occurrence of CARC CO 237 denoting more than one Medicare payment reduction. While this change addresses the issue for all impacted claims crossing over to MA on and after April 24, 2015, MA has no means at its disposal to correct for those crossover claims that may have been rejected and subsequently not processed in PROMISe™ during the period of January 1, 2015 through April 23, 2015. Please see the following instructions which include 1) common characteristics to identify potentially impacted claims and 2) an explanation of how impacted claims should be billed to MA to avoid problems with claim submissions.

1.) **Identification of impacted claims**:
Claims impacted by the issue explained above will share all of the following characteristics.
   a.) Part B (professional) non-DME claims for Medicare/MA dual eligible beneficiaries only AND
   b.) Claims adjudicated by Medicare (CMS) with dates of service on or after January 1, 2015 AND
   c.) Claims for which Medicare (CMS) applied the combination of group code CO and CARC 237 more than once for a given claim detail. On the ASC 835 X12 v.5010 prepared by Medicare, the CARCs are reported in the CAS segment.

2) **Billing considerations and instructions for impacted claims (both past claims and ongoing claims):**

Within the timeframe of January 1, 2015 through April 23, 2015, MA would have systematically dropped any claim meeting the characteristics listed in item 1) above, which had been crossed over to MA directly from Medicare (CMS). As of April 24, 2015, MA implemented a change to begin to permit only those impacted claims received directly from Medicare from that day forward. MA has no means at its disposal to retrieve any impacted claims dropped due to this issue. Furthermore, no exceptions exist for any claim billed directly to MA (other than those received directly from Medicare) using duplicate group code/CARC combinations for the same detail. Any such claims submitted to MA electronically will continue to be rejected for reason of duplicate CARC.

The only way to address and resolve Medicare crossover claims previously dropped by MA is to bill those claims directly to MA. To prevent rejection of claims for reason of duplicate CARC when billing MA directly, use the following billing instructions with respect to CARC CO 237.

For all claims media [e.g. electronic, internet, and paper], providers are directed to:

a). Sum the monetary amounts associated to each individual occurrence of CARC CO 237 appearing on a single detail line as provided by Medicare.

AND

b). Represent the summed total of monetary amounts from step a.) above as a single entry of CARC CO 237 for that same detail.

For example:
Medicare reports the following CARCs for a claim detail where HCPC code 72148 is billed for $238.00.

Group Code	CARC	Monetary Amount
CO	45	167.05
CO	237	1.01
CO	237	2.02
CO	237	3.03
CO	253	1.14
PR	2	14.19

All CARC CO 237 occurrences are identified in blue and step a.) from the instructions above is applied as shown in the first table on the following page.

CO	237	1.01
CO	237	2.02
CO	237	3.03
	Total:	**6.06**

Then step b.) is applied when preparing the claim detail for submission to MA in a manner consistent with the following.

Group Code	CARC	Monetary Amount
CO	45	167.05
CO	237	**6.06**
CO	253	1.14
PR	2	14.19

PROMISe™ only wants the sum of CARC CO 237 reported one time per claim line. For this example, PROMISe™ only wants to see a single CARC CO 237 for the detail but with a combined monetary amount of $6.06.

Thank you for your service to our MA recipients.
We value your participation.
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