CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 11794	**Date: January 19, 2023**
	Change Request 13008

SUBJECT: Preventing Submission of Cross-Reference Document Control Numbers on Original Claims

I. SUMMARY OF CHANGES: The purpose of this change request is to create a new edit in Original Medicare systems to prevent providers from submitting unnecessary data on original claims.

EFFECTIVE DATE: April 1, 2023 - Design and coding.; July 1, 2023 - Testing and implementation; for claims received on or after this date.
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 3, 2023 - Design and coding.; July 3, 2023 - Testing and implementation.

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	1/130.1/General Rules for Submitting Adjustment Requests
R	1/160/Identifying Institutional Providers
R	1/160.1/Reporting of Taxonomy Codes (Institutional Providers)

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: 11794	Date: January 19, 2023	Change Request: 13008

SUBJECT: Preventing Submission of Cross-Reference Document Control Numbers on Original Claims

EFFECTIVE DATE: April 1, 2023 - Design and coding.; July 1, 2023 - Testing and implementation; for claims received on or after this date.
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 3, 2023 - Design and coding.; July 3, 2023 - Testing and implementation.

I. GENERAL INFORMATION

A. Background: Home Health and Hospice Medicare Administrative Contractors (HH&H MACs) have reported cases in which Home Health (HH) original claims (Type of Bill 0329) are submitted and processed with a Cross-Reference Document Control Number (XREF DCN). The XREF DCN is a data element only required on adjustment claims, to ensure the adjustment is associated with the correct original claim. Original HH claims with XREF DCNs are accepted but they create processing problems in the Healthcare Integrated General Ledger Accounting System (HIGLAS). To prevent this error, this change request modifies Original Medicare claims processing systems to return claims with Type of Bill 0329 if an XREF DCN is present on submission.

This change request also updates outdated material in the Medicare Claims Processing Manual regarding the transition to National Provider Identifiers.

B. Policy: This change request contains no new policy.

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	
13008.1	The contractor shall return to provider a HH claim (Type of Bill 0329) if a cross-reference document control number (XREF DCN) is present.	X		X		X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
13008.2	Medicare Learning Network® (MLN): CMS will market provider education content through the MLN Connects® newsletter shortly after CMS releases the CR. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 instructions for distributing the MLN Connects newsletter information to providers and link to relevant information on your website. You may supplement MLN content with your local information after we release the MLN Connects newsletter. Subscribe to the "MLN Connects" listserv to get MLN content notifications. You don't need to separately track and report MLN content releases when you distribute MLN Connects newsletter content per the manual section referenced above.	X		X		

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
13008.1	TOB 0329 will be added to FISS reason code 30921, which returns other original claims if an XREF DCN is reported.

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Wil Gehne, wilfried.gehne@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 1 - General Billing Requirements

Table of Contents
(Rev.11794, Issued: 01-19-23)

130.1 - General Rules for Submitting Adjustment Requests

(Rev.11794, Issued:01-19-23, Effective: 04-01-23, Implementation:04-03-23)

Adjustment requests are the most common mechanism for changing a previously accepted bill. They are required to reflect the results of QIO medical review. CMS may also require adjustments if it discovers that bills have been accepted and posted in error to a particular record. Adjustments that only recoup or cancel a prior payment are "credits" and must match the original in the following fields:

- Intermediary control number (ICN/DCN);
- Surname;
- Medicare beneficiary identifier

When a definite match cannot be made on the three fields above, the provider's *MAC* will use the fields below as needed. Note that for older claims, ICN/DCN probably will not match.

- Date of birth;
- Admission Date for inpatient, (Date of First Service for outpatient) unless changed by this adjustment requests; and
- From/thru dates for inpatient, (Date of First Service/Date of Last Service for Outpatient), unless changed by this adjustment request.

Cancel-only adjustment requests are not acceptable, except in cases of incorrect provider identification numbers and incorrect Medicare beneficiary identifier. The provider must submit a corrected replacement bill (bill type xx1) to its *MAC* after submitting the cancel-only request for the incorrect bill.

The provider must submit all other adjustment requests as debits only. It shows the ICN/DCN of the bill to be adjusted as described above, with the bill type shown as xx7. It submits adjustment requests to its *MAC* either electronically or on hard copy. Electronic submission is preferred. *The ICN/DCN of an associated claim shall only be reported on adjustments. The MAC shall return to the provider any original claim reporting information in this field.*

The *MAC* must enter the following bill types that relate to the entity generating the adjustment request:

xx7	Provider (debit)
xx8	Provider (cancel)
xxF	Beneficiary
xxG	CWF
xxH	CMS
xxI	*MAC*
xxM	MSP
xxP	QIO
xxJ	Other
xxK	OIG/GAO

The provider submits all adjustment requests as bill type xx7 or xx8. Since several different sources can initiate an MSP adjustment (e.g., the provider, CWF, or the *MAC*), the MSP designation, xxM, takes priority over any other source of an adjustment except OIG/GAO. When the provider submits an MSP adjustment request, the *MAC* will change the bill type to xxM. These priorities refer only to the designation of the source of the adjustment. The difference between CWF generating the adjustment request and CMS generating the adjustment request is: An adjustment request is CWF-generated if the *MAC* receives a CWF *unsolicited response,* alert or a CMS-L1002.

The *MAC* prepares an adjustment if instructed by CMS CO or CMS RO to make a change. Typically, such direction from CMS *is to* retroactively change payment for a class or other group of bills. Occasionally, CMS will discover an error in the processing of a single bill and direct the *MAC* to correct it.

If adjustments are rejected by CWF for additional corrections, they must be corrected and resubmitted. Even if a letter from CMS requests the adjustment action, the *MAC* must submit the adjustment request in its CWF record. If a rejected adjustment request is determined to be unnecessary, the *MAC* stops the adjustment action upon receipt of correction.

Where an adjustment request changes subsequent utilization, the *MAC* notes this and processes adjustments to subsequent bills if it services the provider.

160 - Identifying Institutional Providers

(Rev.11794, Issued:01-19-23, Effective: 04-01-23, Implementation:04-03-23)

Since May 23, 2007, Medicare institutional providers submit only the ten position numeric "National Provider Identifier" (NPI) as their provider identifier.

References to the six position alpha-numeric *CMS Certification Number (CCN)* (*previously called the OSCAR number*) found throughout the chapters of the Medicare Claims Processing Manual, on an ongoing basis, are supplied only for the purpose of CMS internal processing. Therefore, these references are documented as "for CMS use only".

160.1 - Reporting of Taxonomy Codes (Institutional Providers)

(Rev.11794, Issued:01-19-23, Effective: 04-01-23, Implementation:04-03-23)

Institutional providers may submit a taxonomy code on claims they submit to Medicare. Medicare does not use the taxonomy code for matching a provider's NPI to the appropriate legacy identifier. Medicare uses other claims data for this purpose. Medicare does not use the taxonomy code for any other claims processing purpose. Payers other than Medicare may have requirements for taxonomy codes. Medicare will pass any taxonomy code submitted on a Medicare claim to our trading partners on crossover claims, to allow for the possibility that those payers may use it.

If an institutional provider chooses to submit taxonomy codes, the following table supplies the crosswalk from Medicare's *CMS Certification Number (CCN)* to the appropriate taxonomy code based on the provider's facility type:

Provider Type	***CCN* Coding**	**Taxonomy Code**
Short-term (General and Specialty) Hospitals	0001-0879 *Positions 3-6	282N00000X
Critical Access Hospitals	1300-1399 *	282NC0060X
Long-Term Care Hospitals	2000-2299 *	282E00000X
Hospital Based Renal Dialysis Facilities	2300-2499*	261QE0700X
Independent Renal Dialysis Facilities	2500-2899*	261QE0700X
Rehabilitation Hospitals	3025-3099 *	283X00000X
Children's Hospitals	3300-3399 *	282NC2000X
Hospital Based Satellite Renal Dialysis Facilities	3500-3699	Type of Bill code 72X + 261QE0700X + different zip code than any renal dialysis facility that is located on that hospital's campus

Psychiatric Hospitals	4000-4499 *	283Q00000X
Organ Procurement Organization (OPO)	P in third Position	335U00000X
Psychiatric Unit	M or S in third Position	273R00000X
Rehabilitation Unit	R or T in third Position	273Y00000X
Swing-Bed Unit	U, W, Y, or Z in third Position	Type of Bill Code X8X (swing bed) with one of the following taxonomy codes to define the type of facility in which the swing bed is located 275N00000X if unit in a short-term hospital (U), 282E00000X if unit in a long-term care hospital (W), 283X00000X if unit in a rehab facility (Y), 282NC0060X if unit in a critical access hospital (Z)