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Standardization of Fiscal Intermediary Use of Group and Claim Adjustment Reason Codes and Calculation and Balancing of TS2 and TS3 Segment Data Elements

Note: This article was revised to contain Web addresses that conform to the new CMS website and to show they are now MLN Matters articles. All other information remains the same.

Provider Types Affected

Providers who bill Medicare fiscal intermediaries (FIs)

Provider Action Needed



STOP – Impact to You

Effective July 1, 2005, The Center for Medicare & Medicaid Services (CMS) will require FIs to report a specific group code in combination with specific reason codes in electronic remittance advice (ERA) and in standard paper remittance advice (SPR) transactions. In addition, CMS has put forth additional requirements for the FI regarding correct calculation for TS2 and TS3 Segment Data Elements in remittance advice transactions.



CAUTION – What You Need to Know

FIs will not use a PR group code unless a claim indicates that a provider obtained an Advanced Beneficiary Notice (ABN) for a service not generally considered as reasonable and necessary for treatment of a patient.



GO – What You Need to Do

To ensure accurate understanding of remittance advice transactions, please review the information included here and remain current with guidelines pertaining to ERA and SPR transactions.

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Background

Effective July 1, 2005, The Center for Medicare & Medicaid Services (CMS) will require FIs to report a specific group code in combination with specific reason codes. In addition, CMS has put forth additional requirements for the FI regarding correct calculation for TS2 and TS3 Segment Data Elements.

The X12 835 remittance advice and 837 coordination of benefits (COB) implementation guides (IG) require that a group code that assigns financial responsibility for a non-paid amount is reported in conjunction with applicable claim adjustment reason codes that explain full or partial denials of services. As part of the continuing effort to foster standardized reporting among fiscal intermediaries, CMS will require FIs to report a specific group code in combination with specific reason codes.

Medicare FIs are permitted to use the following group codes in combination with specific reason codes:

- CO (Contractual Obligation) => provider is financially liable;
- CR (Correction and Reversal) => no financial liability;
- OA (Other Adjustment) => no financial liability; and
- PR (Patient Responsibility) => patient is financially liable.

Please note that although X12 permits use of group code PI (payer initiated), with an adjustment reason code, CMS has never permitted Medicare FIs to use this group code as it fails to identify financial liability for the unpaid amount.

FIs will not use alternate group and reason code combinations unless a claim indicates that a provider obtained an Advanced Beneficiary Notice (ABN) or other notice of non-coverage for a service Medicare may not pay because it is generally not considered reasonable and necessary for treatment of a patient or if the item and/or service is one for which the financial liability protections in Section 1879 of the Social Security Act (SSA) could apply.

Example: Case One: A patient signed an ABN indicating that:

- The provider advised the patient before rendering and billing for a service that the service is not usually covered by Medicare because it is deemed to be not necessary and reasonable , AND
- The patient still requested the service and agreed to pay for the service if denied by Medicare:

Group code PR (patient responsibility) applies with reason code 50 (used to deny a service not considered reasonable and necessary).

Case Two: The provider did not obtain an ABN from a patient for a service not considered reasonable and necessary. In this case, group code CO (contractual obligation) applies with reason code 50.

A provider is prohibited from billing a Medicare beneficiary for any adjustment amount identified with a CO group code, but may bill a beneficiary for an adjustment amount identified with a PR group code.

In addition, CMS has also put forth additional requirements for the FI regarding TS2 and TS3 Segment Data Elements. Most of these data elements report totals for categories of data elements reported elsewhere in an 835. Although the X12 835 IG does not specifically require that these totals balance

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against the applicable individual data elements, CMS will require that these totals balance. In most cases, the amounts to be included in a TS2 or TS3 data element totals are evident from the applicable semantic note.

The following two tables list the semantic notes from the X12 workbook that apply to these segments and data elements. When reported, these data elements must comply with these semantic notes.

TS3 Segment – Transaction Statistics

Number	Code/Description of Code
01	TS301 is the provider number.
02	TS302 is the facility type code
03	TS303 is the last day of the provider's fiscal year.
04	TS304 is the total number of claims.
05	TS305 is the total of reported charges.
06	TS306 is the total of covered charges.
07	TS307 is the total of noncovered charges.
08	TS308 is the total of denied charges.
09	TS309 is the total provider payment.
10	TS310 is the total amount of interest paid.
11	TS311 is the total contractual adjustment.
12	TS312 is the total Gramm-Rudman Reduction.
13	TS313 is the total Medicare Secondary Payer (MSP) primary payer amount.
14	TS314 is the total blood deductible amount in dollars.
15	TS315 is the summary of non-lab charges.
16	TS316 is the total coinsurance amount.
17	TS317 is the Health Care Financing Administration Common Procedural Coding System (HCPCS) reported charges.
18	TS318 is the total Health Care Financing Administration Common Procedural Coding System (HCPCS) payable amount.
19	TS319 is the total deductible amount.
20	TS320 is the total professional component amount.
21	TS321 is the total Medicare Secondary Payer (MSP) patient liability met.
22	TS322 is the total patient reimbursement.
23	TS323 is the total periodic interim payment (PIP) number of claims.
24	TS324 is total periodic interim payment (PIP) adjustment.

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TS2 Transaction Supplemental Statistics

Number	Code/Description of Code
01	TS201 is the total diagnosis related group (DRG) amount.
02	TS202 is the total federal specific amount.
03	TS203 is the total hospital specific amount.
04	TS204 is the total disproportionate share amount.
05	TS205 is the total capital amount.
06	TS206 is the total indirect medical education amount.
07	TS207 is the total number of outlier days.
08	TS208 is the total day outlier amount.
09	TS209 is the total cost outlier amount.
10	TS210 is the diagnosis related group (DRG) average length of stay.
11	TS211 is the total number of discharges.
12	TS212 is the total number of cost report days.
13	TS213 is the total number of covered days.
14	TS214 is total number of non-covered days.
15	TS215 is the total Medicare Secondary Payer (MSP) pass-through amount calculated for a non-Medicare payer.
16	TS216 is the average diagnosis-related group (DRG) weight.
17	TS217 is the total prospective payment system (PPS) capital, federal-specific portion, diagnosis-related group (DRG) amount.
18	TS218 is the total prospective payment system (PPS) capital, hospital-specific portion, diagnosis-related group (DRG) amount.
19	TS219 is the total prospective payment system (PPS) disproportionate share, hospital diagnosis-related group (DRG) amount.

Additional Information

The official instruction issued to your FI regarding this change can be found at <http://www.cms.hhs.gov/transmittals/downloads/R470CP.pdf> on the CMS website.

If you have questions regarding this issue, you may also contact your fiscal intermediary at their toll-free number, which may be found at

<http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

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