CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11569	**Date: August 18, 2022**
	Change Request 12710

Transmittal 11376, dated April 29, 2022, is being rescinded and replaced by Transmittal 11569, dated, August 18, 2022 to change the implementation date. All other information remains the same.

SUBJECT: Medicare Summary Notice (MSN) Created with Wrong Beneficiary Data - Update Beneficiary Data Streamlining Logic

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is, an A/B Medicare Administrative Contractor (MAC) for Part B, has identified instances where MSNs are being created for the wrong beneficiary when there is a Medicare Beneficiary Identifier or Health Insurance Claim Number (HICN) mismatch to the name submitted on a claim. Medicare claims submitted with the wrong beneficiary eligibility information should be rejected back to the submitter of the claim as unprocessable and the MSN should be suppressed.

EFFECTIVE DATE: August 8, 2022 - for requirements effective date; October 1, 2022 - for release billing purposes
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: August 8, 2022 - for requirements effective date; October 3, 2022 - for release billing purposes

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/A	N/A

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:
One Time Notification

Attachment - One-Time Notification

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I. GENERAL INFORMATION

A. Background: The CMS has been made aware of instances where a beneficiary has contacted 1-800 Medicare, reporting an issue of receiving an MSN with services not provided to them by a provider in which they do not belong. The Medicare Administrative Contractor (MAC) is contacted and upon research, the claim was submitted for a beneficiary other than the beneficiary who received the MSN. This issue is occurring due to the claim not being returned to the submitter as unprocessable by the Multi-Carrier System (MCS) when the Common Working File (CWF) receives a valid HICN with a name that does not match.

The MAC is unaware of the number of instances where this is occurring, as it is only identifiable upon the beneficiary questioning the services.

CMS CR 7260 addresses the system's logic that shall be applied by the MCS when the CWF returns a 08 trailer with the 5052-error code, and disposition 55. The claim shall be rejected and the MSN shall be suppressed.

The Part B MAC, entered multiple test claims. Through the analysis of those results, this issue seems to be limited to the MCS Beneficiary Data Streamlining (BDS) application, designed under CMS CR 8091. Specifically, the following section of the logic defined under MCS S2300000:

The BDS response is returned and held on a file until the claim moves to Medical Policy. When the claim moves to Medical Policy the BDS response is applied to the claim. However, the claim will still process through pre-CWF auditing and may suspend.

When a claim is split, the BDS response is matched to the claim based on BDS line number fields held on the claim in MCS.

TEST INPUT: A claim was entered with a HIC/Name Mismatch and contained two detail lines.

TEST OUTPUT: The BDS application within the MCS rejected one detail line for the 5052/55 audit 202A as expected. The other detail line was denied per a MAC local edit. The MCS systematically split the rejected detail line off the original claim to another Internal Control Number (ICN). The denied detail line that remained on the original claim ICN finalized without transmitting to CWF. The claim did not move to the CWF location 060 and receive a 01-acceptance response to finalize within MCS. It would be expected that the claim transmits to CWF, receives a 5052/55 and would not finalize creating the MSN.

It is assumed, that because the BDS logic is not applied until a medical policy location within MCS, that any edit that has a priority to set prior to that location is taking priority over an eligibility rejection within the

BDS logic.

B. Policy: There are no policy changes associated with this instruction.

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	
12710.1	The MCS shall reject a claim receiving the 5052-error code with a disposition 55 and the MSN shall be suppressed, as directed under CMS CR 7260.						X			
12710.1.1	The MCS shall ensure the BDS auditing takes priority over edits.						X			
12710.1.1.1	The MCS shall insure claim denials are transmitted to the CWF and not finalized outside of the CWF without a response. A description of this occurring can be found in the background section of this CR.						X			
12710.2	National Government Services (NGS) shall be the sponsoring Part B MAC for this CR.		X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

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): Cathleen Gurreri, 443-934-2913 or Cathleen.Gurreri@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
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ATTACHMENTS: 0