CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 11504	**Date: July 21, 2022**
	Change Request 12792

SUBJECT: Modification of Existing Common Working File (CWF) Editing for Preventive Services

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to modify existing Common Working File (CWF) editing for preventive services. In some instances, when claims are paid outside the CWF, the beneficiary's claim history is not updated in the CWF, leading to incorrect claim's history. To avoid this and make CWF information more accurate, this CR allows frequency limitation editing to be overridden by contractors. In addition, this CR updates IOM Pub.100-04, Chapter 4, Section 300.5.

EFFECTIVE DATE: January 1, 2023
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 3, 2023

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	4/300/300.5/ General Claims Processing Information

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: 11504**	**Date: July 21, 2022**	**Change Request: 12792**

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EFFECTIVE DATE: January 1, 2023
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I. GENERAL INFORMATION

A. Background: The Common Working File maintains Medicare claim history and entitlement information for the beneficiary. Currently, there are reason codes within the CWF that enforce policy on frequency limitations for preventive services. When an incoming claim exceeds the frequency, limitation established for a particular service, CWF rejects the claim and the claim is ultimately denied. In some instances, due to review determinations (e.g., Qualified Independent Contractor (QIC) or administrative law judge (ALJ) reviews) contractors must pay the claim outside the CWF in order to effectuate the decision.

When claims are paid outside the CWF, the beneficiary's claim history is not updated in the CWF, leading to incorrect information about the last date the service was covered. To avoid this and make CWF information more accurate, CWF shall allow frequency limitation editing to be overridden by contractors.

In addition, this CR updates the Internet-Only-Manual Pub.100-04, Chapter 4, Section 300.5.

B. Policy: No change in 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	
12792.1	The contractor shall allow frequency limitation edits to be overridden, for preventive screening claims processed on or after January 1, 2023.								X	HETS, MBD, NGD
12792.2	Contractors shall, upon a favorable determination evidencing medical necessity and to satisfy all other Medicare rules for such service, pay the claim using the newly created override, assuming all other coverage requirements are met.	X								
12792.3	Medicare contractors shall add the determination case number to the claim record before applying the override on the reason codes.	X								

Number	Requirement	Responsibility								
		A/B MAC			D M E M A C	Shared-System Maintainers				Other
		A	B	H H H		F I S S	M C S	V M S	C W F	
	NOTE: The MAC shall request approval from the COR, if the MAC believes a frequency edit is suitable for an override in a case that does not have a review or appeal case number.									
12792.4	Contractors shall be in compliance with the updates to CMS IOM Publication 100-04, Chapter 4, subsection 300.5.	X	X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			D M E M A C	C E D I
		A	B	H H H		
	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): Bill Ruiz, 410-786-9283 or william.ruiz@cms.hhs.gov , Kajol Balani, 410-258-9780 or kajol.balani@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

300.5 - General Claims Processing Information

(Rev.11504, Issued 07-21-22; Effective:01-10-23; Implementation: 01-03-23)

This benefit is payable for beneficiaries who have diabetes or renal disease. Contractors are urged to perform data analysis of these services in your jurisdiction. If you determine that a potential problem exists, you should verify the cause of the potential error by conducting an error validation review as described in the Program Integrity Manual (PIM), Chapter 3, Section 2A. Where errors are verified, initiate appropriate corrective actions found in the PIM, Chapter 3, Sections 3 through 6. If no diagnosis is on the claim, return the claim as unprocessable. If the claim does not contain a diagnosis of diabetes or renal disease, then deny the claim under Section 1862(a)(1)(A) of the Act.

A. Special Requirements for A/B MACs (B)

- Registered dietitians and nutrition professionals can be part of a group practice in which case the provider identification number of the registered dietitian or nutrition professional that performed the service must be entered in on the claim form.

    - The specialty code for "dietitians/nutritionists" is 71.

B. Medicare Summary Notices (MSNs)

- Use the following MNT messages where appropriate. If you locate a more appropriate message, then you should use it.

    - If a claim for MNT is submitted with dates of service before January 1, 2002, use MSN 21.11 (This service was not covered by Medicare at the time you received it). The Spanish version is 'Este servicio no estaba cubierto por Medicare cuando usted lo recibio.'

    - If a claim for MNT is submitted by a provider that does not meet the criteria use MSN 21.18 (This item or service is not covered when performed or ordered by this provider). The Spanish version is 'Este servicio no esta cubierto cuando es ordenado o rendido por este proveedor.'

C. A/B MAC (A) Special Billing Instructions

MNT Services can be billed to A/B MACs (A) when performed in an outpatient hospital setting. The Hospital outpatient departments can bill for the MNT services through the A/B MAC (A) if the nutritionists or registered dietitians reassign their benefits to the hospital. If the hospitals do not get the reassignments the nutritionists and the registered dietitians will have to bill the Medicare A/B MAC (B) under their own provider number or the hospital will have to bill the Medicare A/B MAC (B).

NOTE: Nutritionists and registered dietitians must obtain a Medicare provider number before they can reassign their benefits.

The only applicable bill types are 13X, 23X, 32X, and 85X.