Program Memorandum Intermediaries

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal A-02-071 **Date: JULY 31, 2002**

CHANGE REQUEST 2154

SUBJECT: Updated Instruction on Receipt and Processing of Non-Covered Charges on Other Than Part A Inpatient Claims

This instruction addresses and corrects some of the issues surrounding Transmittal A-01-130, Change Request 1769. This document gives clear instructions on how the Common Working File (CWF) and Fiscal Intermediary (FI) standard systems (SSs) are to accept non-covered charges on a claim.

The scope of claims affected remains the same. The initiatives listed below will result in Medicare providers and systems generating an increased volume of non-covered charges:

- HH PPS demand bills;
- HH PPS consolidated billing (CB);
- SNF PPS CB, last phase scheduled for July 1, 2002;
- Enforcement of hospital bundling requirements (outpatient); and
- Automation of the coordination of benefits process (crossing over of paid claims).

The initiatives above affect the following types of bills:

12x	**32x**	**72x**	**81x**
13x	**33x**	**73x**	**82x**
14x	**34x**	**74x**	**83x**
22x	**41x**	**75x**	**85x**
23x	**71x**	**76x**	

For demand bills, billing for denial, and other reporting of non-covered charges, this Program Memorandum (PM) supersedes instructions currently in §3604 of the Medicare Intermediary Manual (MIM), Part 3, which state: "For outpatient Part B billing, only charges believed to be covered are submitted in [form locator] FL 47. Non-covered charges are omitted from the bill."

The following chart explains how to report non-covered charges and total charges using the different claim formats:

Claim Format	Total Charges	Non-covered Charges
UB-92 flat file	Use record type 61 Field No. 11	Use record type 61 Field No. 12
X12 837,version3051 implementation 3A.01	2 395 SV203	2 395 SV207
X12 837,version3051 implementation 1A.C1	2 375 SV203	2 375 SV207
X12 837,version 4010 (HIPAA)	2400 SV203	2400 SV207
Hard copy UB-92	[Form Locator] FL 47	[Form Locator] FL 48

Processing of Claims

If a provider submits a non-covered charge with nothing in the total charge field, FI SSs are to install an edit to Return to Provider (RTP) the bill. Non-covered charges must be equal to or less than total charges on the line on which they appear.

Previously, when providers had both covered and non-covered charges for a given HCPCS or revenue code, they were required to split these into separate bills. Effective for bills with dates of service on and after April 1, 2002,when providers have an instance in which there are covered and non-covered units for services for a single HCPCS or revenue code, that could be submitted on a single line instruct your provider to split such submissions into two lines, one with all the covered charges and the other with all of the non-covered charges.

FIs must instruct their providers if units come in with non-covered charges put them on the non-covered line. If units come in with covered charges, put them in the covered charges line. If FIs deny units, show the number of denial units in the field on the denied (non-covered) line.

FI SSs will not roll-up lines with non-covered charges into other line items. FI SSs will not be required at this time to automate the splitting of lines with both covered and non-covered charges. However, the systems must accommodate lines that have been manually split by FIs, for reasons such as denying some, but not all, units on a line in the course of medically reviewing a claim.

Special Instructions for Home Health Claims

The only exception to the new requirement to split covered and non-covered service lines is for Home Health Demand Bills. For home health bills, covered and non-covered charges for the same visit must be on the same line in order for Medicare Systems to correctly calculate visits. This line should include a non-covered charge amount equal to the portion of charges to be submitted for consideration by other insurance and a total charge amount equal to the sum of the non-covered amount and the portion of charges potentially covered by Medicare. Units reported on this line item should represent the entire elapsed time of the visit (the sum of the covered and non-covered portions), represented in 15-minute increments.

Prior to April 2002, HH claims submitted for denial notice using condition code 21 (also called no-pay bills) were not submitted to CWF since they were entirely non-covered. As a result, CWF episode editing has not previously been modified to reflect the HH no-pay bill process outlined in MIM 3638.31 and no-pay bills received since April 2002 are being rejected by CWF. CWF must revise their editing to allow no-pay bills without an accompanying RAP. Additionally, CWF must process no-pay bills without creating a new episode based on the no-pay bill. Finally, no-pay bills should not be rejected because a corresponding episode is not posted to CWF, or because the no-pay bill overlaps an episode established for the provider submitting the no-pay bill.

REQUIREMENTS FOR MEDICARE

Denials

Claims with non-covered charges, submitted by providers or resulting from FI review or medical review (MR) must be forwarded to CWF with the appropriate Accredited Standards Committee ASC X-12 group, adjustment reason or remark codes. This must be done for both non-covered charges and covered charges on otherwise covered claims, and entirely non-covered claims. FI SSs must provide a complete CWF input record for these claims, totaling the charges on the CWF input under revenue code 0001 (covered and non-covered). When claims are totally non-covered (TOB = XX0), the reasons for non-coverage are shown on the 0001 line. Currently, Medicare systems are limited to carrying no more than four ASC reason/remark codes per line. If the services on a claim are non-covered for multiple reasons requiring more than four codes, report the first four codes appearing on the claim on the 0001 line.

Rejects

Claims or lines rejected as a duplicate payment need not be sent to CWF. The following types of rejects should not be sent to CWF:

- CWF and FI duplicates;
- CWF rejects for entitlement;
- CWF rejects for claims that overlap risk HMO periods;
- CWF rejects for hospice election periods;
- CWF rejects for A/B crossover edits, and;
- CWF rejects for HH PPS Episodes.

The outpatient CWF records (HUOP and HUHH) have been expanded to create a non-covered revenue line field to accept and pass non-covered charges to the National Claims History (NCH) File. Non-payment codes are required in CWF records where no payment is made for the entire claim. Therefore, CWF will utilize the non-payment codes in §3624 of the MIM and the Medicare Secondary Payer (MSP) Cost Avoidance codes as detailed in the MSP Savings Manual §3899 for Intermediary.

Standard systems must enter the appropriate code in the "Non-payment Code" field of the CWF record if the non-payment situation applies to all services present on the claim. The primary payer uses appropriate MSP value codes and amounts to describe. Therefore, CWF will utilize the non-payment codes in §3624 of the MIM and the MSP Cost Avoidance codes as detailed in the MSP Savings Manual §3899 for Intermediary.

For denials and rejects, annotate with the appropriate remittance advice and Medicare Summary Notice codes. This applies to the following situations:

- The claim is cost avoided; and
- Any other situation which you reject/deny the claim as a result of edits in your standard systems.

FI SSs must make these changes.

Condition Codes 20 and 21

If FIs receive a completely non-covered claim without either a condition code 20 or a condition code 21, process the claim through your system. All non-covered claims must be processed as provider liable unless occurrence code 32 and date is present signifying that an advance beneficiary notice was given to the beneficiary on that date, or, unless the service is non-covered by statute.

If a beneficiary demands a Medicare determination for any line(s) for other than Home Health services, instruct the provider to put those line(s) on a separate bill showing the charges as non-covered and put condition code 20 on the bill. If a beneficiary wants an MSN for denial reasons on

any line(s) for other than Home Health services, put those line(s) on a separate bill and show condition code 21 on that bill. The SS will generate denial reasons for the lines containing non-covered charges. Home Health services are addressed in a previous section of this instruction.

Note: The use of occurrence code 32 should be made specific to all claim types except Home Health bills. Since there is only one occurrence code (32) to indicate the date the beneficiary received an ABN, only lines for which you notified the beneficiary on the same date may be submitted on the same bill for both demand bills and billing for denial bills (condition codes 20 and 21). If you gave ABNs on different dates for different procedures, show the services and the dates you gave ABNs on separate bills for each date involved

Edits

Neither FI SS nor CWF will discontinue current consistency editing because of this instruction, unless such edits serve solely to prevent the acceptance of non-covered charges on other than Part A inpatient claims.

All Pricers will continue to receive and process only covered line items. The CMS expects FI SSs to make appropriate accommodations to ignore OCE edits for lines with non-covered charges.

The NCH will assure all non-covered charges accepted by CWF, including those for inpatient claims, would be received with valid revenue codes, but clearly indicated as non-covered.

MSN Message

Use the most appropriate MSN message for all non-covered lines and claims. If FIs do not know why the provider submitted the line(s) is/are as non-covered, use MSN message 16.55 "The provider billed this charge as non-covered." The Spanish translation for MSN message 16.55 is "El proveedor facturó este cargo como no cubierto."

Contractor Workload

FIs *may* experience an increase in workload reporting at the implementation date of the PM. This impact could be immediate for FI claims processing systems, and may affect FIs after duplicate payment edits are installed.

The *effective date* for this PM is claims with dates of service on and after January 1, 2003.

The *implementation date* for this PM is January 1, 2003.

These instructions should be implemented within your current operating budget.

This PM may be discarded after December 31, 2003.

If you have any questions, contact **Cindy Murphy** at 410-786-5733 or cmurphy1@cms.hhs.gov or Antoinette Johnson, ajohnson2@cms.hhs.gov.