Medicare
Carriers Manual
Part 3 - Claims Process

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

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CHANGE REQUEST 1927

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
4267 - 4267.1	4-65 - 4-66 (2 pp.)	4-65 - 4-66 (2 pp.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE:* October 1, 2002
***IMPLEMENTATION DATE: October* 1, 2002**

Section 4267.1, Claims Processing Procedures for Physician/Supplier Services to HMO Members, is revised to implement new procedures for handling misdirected claims for services for HMO members. Misdirected claims for services that should be billed to an HMO by the service provider will be denied, and the provider is notified via claim level remittance advice reason code messages 109 that the services should be billed to the patient's managed care plan.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

These instructions should be implemented within your current operating budget.

Reimbursement for non-member services furnished on a fee basis are made through you in all cases and are subject to a "reasonable charge" determination. The plan may bill the patient directly or accept assignment in these instances.

4265. BILLING BY ORGANIZATIONS ON HCFA-1500 OR HCFA-1490U

Organizations request payment on either HCFA-1500 or HCFA-1490U.

The form HCFA-1490U may be used by organizations which prefer to bill on a single form. This form combines the necessary information from the HCFA-1500 with a certification statement required in accordance with §7065D.

Instructions for completion of HCFA-1490U form are on the reverse of the form. (See §4999, Exhibit 5.)

The organization completes all necessary information in Part I of either the HCFA-1500 or HCFA-1490U. This includes:

- Patient's name, HICN, sex, and address. The address is shown in item 4 of the HCFA-1500.

- Organizational name, address, and approval number in Item 5 of Form HCFA-1490U. When the HCFA-1500 is used, the equivalent information of Item 5 must be shown on an attachment. (See §7065D.)

- ICD-9-CM coding is required for each diagnosis and must correlate to each procedure or service rendered by a physician beginning April 1, 1989. See §4030.2, Item 23A for additional information.

- Signature of an authorized organization official. When the Form HCFA-1500 is used, the signature will be shown on the organization's attachment.

The claim form need not be signed by the enrollee. The organization should furnish sufficient itemization of the services it has paid for (with diagnosis, dates of services, places of service, and charges) to enable a reasonable charge determination to be made. This may be done by submitting Part II of the HCFA-1500, signed by the physician or an itemization on the attached physician's bill form(s).

4267. HEALTH MAINTENANCE ORGANIZATION (HMO) - CLAIMS FOR PHYSICIAN/SUPPLIER SERVICES FURNISHED TO HMO MEMBER

Process claims for items or services provided to an HMO member over which you have jurisdiction (see §9050.2) in the same manner as you process other Part B claims for items or services provided by physicians or suppliers. (See §§40l0-4265 and 4270-4272.l.)

NOTE: See §§9050ff. for HMO qualifications and for conditions of payment to HMO's.

4267.l Claims Processing Procedures for Physician/Supplier Services to HMO Members.--Generally, the physician/supplier who provides in-plan services to its HMO members submits his bill directly to the HMO for payment and normally does not get involved in processing the claim. (See §9050C.) However, in some cases, claims for services to HMO members are also submitted to carriers, e.g., where claims are received from physicians for dialysis and related services provided through a related dialysis facility.

If the CWF reply (trailer 05) indicates that the patient is a member of an HMO, take appropriate action as described below based on the code shown in the trailer portion of the CWF reply.

l. Option Codes A, B, or C.--Deny non-dialysis portions of these claims and generate claim level remittance advice message 109 to let the biller know that the denied service needs to be billed to the patient's managed care plan. Also generate Medicare Summary Notice message 11.3 or EOMB message 11.5, as appropriate.

If the CWF reply indicates end stage renal disease (ESRD) involvement (Option Codes A, B, C), process all dialysis and related services on the claim that were furnished within your service area and send a payment determination notice to the beneficiary's HMO. For ESRD related services furnished outside your service area, follow §3110ff.

2. R-trailer Code l or 2.--Process all received claims in the usual manner showing R-trailer codes and sends a notice of payment to the HMO.

3. The Beneficiary is a Member of an HMO for only a Portion of the Bill.--A bill may include services furnished when the beneficiary was a member and services furnished when the beneficiary was not a member of an HMO. If the option code is A, B, or C, split the bill, process the non-member portion and return/reject the HMO portion to the biller along with claim level remittance advice message 109 instructing the service provider to submit a claim to the beneficiary's HMO for the returned/rejected services. If the trailer code is 1 or 2, process the claim without splitting the bill. Do not reject payment records, that overlap an HMO enrollment period, the option code is 1 or 2.

In addition, if the bill is from a physician for dialysis and related services rendered and the bill overlaps an HMO member's entitlement period where the member is a restricted beneficiary (see §9050D), split the bill and process the services furnished outside of the member's HMO entitlement period and those furnished wholly within the member's entitlement period separately.

4267.2 Procedures for Handling Claims Transferred by the HMO.--HMOs may send billings to you for various reasons. Resolve the issue by requerying or recontracting the HMO, if necessary, and take appropriate action as follows:

- If the beneficiary is not a member of a HMO, process the claim.