Medicare
Intermediary Manual
Part 3 - Claims Process

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

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CHANGE REQUEST 2624

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
Table of Contents - Chapter IV	3-73 - 3-73.1 (2 pp.)	3-73 - 3-73.1 (2 pp.)
3301.1 - 3314 (Cont.)	3-74.1 - 3-74.7 (7 pp.).	3-74.1 - 3-76.2 (18 pp.)
Table of Contents	6-1 -6-2 (2 pp.)	6-1 - 6-2 (2 pp.)
3600.1 (Cont.)	6-11.4 (1 pp.)	6-11.4 - 6-11.5 (2 pp.)
3600.2 - 3600.5	6-14.1 - 6-15 (11 pp.)	6-14.1 - 6-16 (4 pp.)
3605.2 - 3605.3	--------	6-64.1 - 6-64.3 (3 pp.)
3873.2	9-202.1 (1 p.)	9-202.1 (1 p.)
Addendum L	L1 - L3 (3 pp.)	L1 - L4 (4 pp.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE: June 13, 2003*
IMPLEMENTATION DATE: June 13, 2003

Section 3301, Filing a Request For Payment, is retitled to reflect that information relating to claims for payment is deleted. The revisions are moved to §3600.2. Cross-references to other deleted sections have also been updated.

Section 3302, Request For Payment, is revised to remove information regarding use of the billing form as a request for payment and to remove references to combined billing practices no longer in use.

Section 3305, Filing Claims For Payment, is deleted and its contents revised and moved to §3600.2.

Section 3307, Time Limits For Requests and Claims For Payment For Services Reimbursed on a Reasonable Cost Basis, is deleted and its contents revised into §3600.2.

Section 3308, Effects on Beneficiary and Provider of Beneficiary's Refusal to File a Request For Payment, is revised to move claim filing related content into §3600.2. The section title is revised to indicate the section only address refusal to file a request for payment.

Section 3309, Filing Claims Where Usual Time Limit Has Expired, is deleted and its contents revised and moved to §3600.2.

Section 3310, Claims for Payment for Emergency Hospital Services and Services Outside the United States, is deleted and its contents revised and moved to §3600.2.

Section 3311, Appeals, is deleted and its contents revised and moved to §3600.2.

Section 3312, Time Limits For Filing Part B Reasonable Charge Claims, is deleted and its contents revised and moved to §3600.2, if still applicable.

Section 3600.1, Claims Processing Timeliness, is revised to remove information defining receipt date and to refer to §3600.2 for that information.

Section 3600.2, Time Limitations for Filing Provider Claims, is revised to clarify Medicare policy on timely filing and to gather all information pertinent to this subject into one manual section.

Section 3605, Incomplete or Invalid Claims, is deleted and its contents revised and moved to §3600.2.

Addendum L, Paper and Electronic Data Element Requirements, is updated to reflect recent changes in Medicare billing requirements.

3873.2, Bill Type Codes and allowable Provider Numbers, is updated to relect current provider numbering information found in the State Operations Manual.

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.

CHAPTER IV
REQUIREMENTS FOR PAYMENT

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Filing for Payment

3301. FILING A REQUEST FOR PAYMENT

Medicare payment may not be made for hospital services, extended care services, or home health services furnished under Part A or Part B, or outpatient physical therapy or speech pathology services furnished under Part B, unless the beneficiary or his representative files a timely written request for payment and the provider files a timely claim. (See §3600.2 for an explanation of time limits.)

The provider should ask the patient to complete the request for payment at the time the covered services begin, if he is or may be a Medicare beneficiary, i.e., he is at least age 65 or there is other reason to believe he may be a beneficiary. If the beneficiary does not file his request upon admission or start of care, he may file it later with the provider or (less preferably) with an intermediary, carrier, or CMS. Once the patient or his representative has filed his request for payment with the provider, the provider (including an emergency or foreign hospital which has elected to bill the program) must file a claim for payment (billing) with its intermediary. (See §3600.2 for provider and beneficiary liability where a claim is not filed timely.)

3301.1 Claims for Payment in Alcohol and Drug Abuse Cases.--The law requires providers to observe more stringent rules when disclosing medical information for claims processing purposes from the records of alcohol and drug abuse patients than when disclosing information for other Medicare beneficiaries. Since the standard consent statement on the provider billing form is not sufficient authority under the law to permit the provider to release information from the records of alcohol or drug abuse patients, more explicit consent statements are required.

Provider participating in the Medicare program that raise issues of confidentiality with intermediaries should be advised to obtain written consent from beneficiaries in each alcohol or drug abuse case. This written consent, which will allow the provider to disclose the records of the patient should include all of the following:

1. The name of the organization (hospital, etc) which is to make the disclosure;

2. The name or title of the person or organization to which disclosure is to be made (e.g., the Centers for Medicare and Medicaid Services, including the appropriate intermediary or carrier, specified by name);

3. The name of the patient;

4. The purpose or need for disclosure (e.g., for processing a claim for Medicare payment and for such evaluation of the treatment program as is legally and administratively required in the overall conduct of the Medicare program);

5. The specific extent or nature of information to be disclosed (e.g., all medical records regarding beneficiary's treatment, hospitalization and/or outpatient care including treatment for drug abuse or alcoholism);

6. A statement that the beneficiary may revoke his consent at any time to prohibit disclosures on or after date of revocation;

7. A statement specifying a date (not to exceed 2 years) event, or condition upon which consent will expire without revocation;

8. The date on which the consent is signed; and

9. The signature of the patient; or the signature of his authorized or legal representative.

If the beneficiary wishes, the consent statement may be expanded to permit disclosure by the provider to any other person, organization, or program, such as PSRO, as appropriate. Authorization may also be given to CMS and its contractors to redisclose specific information to third party payers for complementary insurance purposes.

The provider should keep the consent statement with the patient's medical and other records. The duration of the consent statement is not to exceed 2 years, after which it must be renewed by the beneficiary if further disclosures are necessary.

3302. REQUEST FOR PAYMENT

3302.1 Billing Form as a Request for Payment. -- The institutional claim form (Form CMS-1450, UB-92) does not have a patient's signature line incorporating the patient's request for payment of benefits. As a result, the billing form itself cannot be used as a request for payment. Requests for payment must be obtained and retained in the provider's records (see §3302.2). The institutional claim form contains a provider representative signature (FL 85) which includes a certification that a request for payment has been obtained from the patient.

3302.2 Request for Payment on Provider Record .--A participating provider (hospital, critical access hospital, skilled nursing facility, home health agency, outpatient physical therapy provider, or comprehensive rehabilitation facility), ESRD facility, independent rural health clinic, freestanding Federally Qualified Health Clinic, Religious Non-Medical Health Care Institution, or Community Mental Health Centers must use a procedure under which the signature of the patient (or his representative under §3302.5) on its records will serve as the request for payment for services of the provider.

To implement this procedure, the provider must incorporate language to the following effect in its records:

Statement to Permit Payment
of Medicare Benefits to Provider and Patient.

NAME OF BENEFICIARY HI CLAIM NUMBER

I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by or in (name of provider). I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

For services furnished to inpatients of a hospital, or SNF, the request is effective for the period of confinement. For services furnished by or in a provider on an outpatient basis, the request is effective until revoked. If a patient objects to part of the request for payment, the provider should annotate the statement accordingly.

In using this procedure, the provider undertakes to make the patient signature files available for intermediary inspection on request.

The intermediary must make periodic audits of signature files selected on a random basis.

3302.3 and 3302.4 have been deleted.

3302.5 Signature on the Request for Payment by Someone Other Than the Patient.--If at all practical, the patient should sign the request on the provider's record at the time of admission or start of care.

In certain circumstances, it would be impracticable for an individual to sign the request for payment himself because when he is admitted to a hospital or skilled nursing facility or first receives outpatient or home health services, he is unconscious, incompetent, in great pain, or otherwise in such a condition that he should not be asked to transact any business. In such a situation, his representative payee (i.e., a person designated by the Social Security Administration to receive monthly benefits on the patient's behalf), a relative, legal guardian, or a representative of an institution (other than the provider) usually responsible for his care, or a representative of a governmental entity providing welfare assistance, if present at time of admission or start of services, should be asked and permitted to sign on his behalf.

A. Provider Signs Request.-- If, at the time of admission or start of care, the patient cannot be asked to sign the request for payment and there is no person present exercising responsibility for him, an authorized official of the provider may sign the request. Except in the outpatient case described below, where the patient is not physically present, a provider should not routinely sign the request on behalf of any patient. If experience reveals an unusual frequency of such provider-signed request from a particular provider, the matter will be subject to review by the intermediary.

The hospital or SNF need not attempt to obtain the patient's signature where the physician sends a specimen (e.g., blood or urine sample) to a laboratory of a participating hospital or SNF for analysis, the patient does not go to the hospital or SNF, but the tests are billed through that provider. The hospital or SNF may sign on behalf of the patient and should note in their records "Patient not physically present for tests." This does not apply in cases in which the patient actually goes to the hospital or SNF laboratory for tests and the provider fails to obtain the patient's signature while he is there.

If it is impractical to obtain the patient's signature because a home health agency does not make a visit to his home (e.g., the physician certifies that the patient needs a certain item of durable medical equipment but no visits are certified), the agency may furnish the equipment and need not obtain the patient's signature. An agency representative should sign on behalf of the patient and note in their records "Patient not visited."

B. Patient Dies.-- If the patient dies before the request for payment is signed, it may be signed by the legal representative of his estate, or by any of the persons or institutions (including an authorized official of the provider) who could have signed it had he been alive and incompetent.

A request for payment for inpatient hospital services filed with the hospital may serve as an application for HI entitlement when filed by or on behalf of a live patient, but not when filed on behalf of a deceased patient. (See §3302.6.)

C. Need for Explanation of Signer's Relationship to Patient.--When someone other than the patient signs the request for payment, the signer will submit a brief statement explaining his relationship to the patient and the circumstances which made it impracticable for the patient to sign. The provider will retain the statement in its files. The intermediary will generally accept such a statement as representing the true facts of the case in the absence of evidence to the contrary. If development is needed for some other reason, the intermediary will ask the provider to furnish the explanation of relationship and circumstances. However, processing the claim should not ordinarily be delayed to obtain the explanation if nothing else prevents payment.

3302.6 Request for Payment as a Claim for Hospital Insurance Entitlement.-- To become entitled to hospital insurance, an individual must not only be eligible, but must also, prior to his death, apply for such entitlement (or for monthly social security benefits) with SSA. Even though he meets all eligibility requirements, if he does not file the necessary application before death, he cannot be entitled to Part A benefits and no payment can be made under the HI program for his hospital services.

Occasionally a patient aged 65 or over who is admitted to a hospital, though eligible, has never applied for monthly benefits and has no health insurance card. In very rare instances he may have a card even though he has not filed the necessary application. To protect the eligible patient, his estate, and the hospital against the possibility that timely application will not be filed with SSA, a written request for title XVIII payment filed with the hospital may serve as an application for hospital insurance entitlement filed with SSA. The request must be filed with the hospital prior to the death of the patient. A prescribed application form properly executed must be filed with SSA within 6 months of the date of SSA's written notice to a proper applicant of the need for such application. Section 307 of the Hospital Manual contains the details of this procedure.

This function of the written request as an informal claim for HI entitlement under certain conditions is distinct from its far more general and basic function as a request that payment may be made on behalf of an entitled individual to the provider. A request for payment in this latter sense can validly be executed after the death of the entitled individual.

3302.7 Refusal by Patient to Request Payment Under the Program.--A patient on admission to a hospital or skilled nursing facility may refuse to request Medicare payment and agree to pay for his services out of his own funds or from other insurance. Such patients may have a philosophical objection to Medicare or may feel that they will receive better care if they pay for services themselves or they are paid for under some other insurance policy. The patient's impression that another insurer will pay for the services may or may not be correct, as some contracts expressly disclaim liability for services covered under Medicare. Where the patient refuses to request Medicare payment, the provider should obtain his signed statement of refusal wherever possible. If the patient (or his representative) is unwilling to sign, the provider should record that the patient refused to file a request for payment but was unwilling to sign the statement of refusal.

In any event, there is no provision which requires a patient to have covered services he receives paid for under Medicare if he refuses to request payment. Therefore, a provider may bill an insured patient who positively and voluntarily declines to request Medicare payment. However, if such a person subsequently changes his mind (because he finds out his other insurance will not pay or for another reason) and requests payment under the health insurance program within the prescribed time limit, the provider must bill the intermediary. If the provider is reimbursed under Medicare it should then refund to the patient any amounts he paid in excess of the permissible charges.

Where a patient who has declined to request payment dies, his right to request payment may be exercised by the legal representative of his estate, by any of the persons or institutions mentioned in §3302.5, by a person or institution which paid part or all of the bill, or in the event a request could not otherwise be obtained, by an authorized official of the provider. This permits payment to the provider for services which would not otherwise be paid for and allows a refund to the estate or to a person or institution which paid the bill on behalf of the deceased.

See §3308 for effect on beneficiary and provider of refusal to file a request for payment. See § 3600.2 for filing claims for payment and for associated time limits.

3308. EFFECT ON BENEFICIARY AND PROVIDER OF BENEFICIARY'S REFUSAL TO FILE A REQUEST FOR PAYMENT

A. Patient Refuses to Request Medicare Payment or Provider Is Unaware of His Eligibility.--The provider may charge the beneficiary for covered services where no timely request for payment is filed by or on behalf of the beneficiary because:

(1) The beneficiary refused to file. (The deductible is credited to his SSA record and utilization days are charged.) Or

(2) The patient failed to bring his entitlement or possible entitlement to the attention of the provider and the provider had no other reason to believe the patient had Medicare. If the patient later brings his entitlement to Part A or Part B (whichever is required for payment for the services) to the provider's attention after the time limit and the bill is not filed timely, the deductible and coinsurance will not be credited and utilization days will not be charged.

B. Late Filing Reveals Continuation of Benefit Period.--The services furnished in (2) above could affect a benefit period in which later services were furnished by linking together what were originally thought to be two benefit periods. For example: Claims were timely filed and payment made for 75 days of inpatient hospital services at hospital A during the period July 20 - October 3 in a given calendar year, and 25 days of inpatient hospital services furnished at hospital C during the period January 15 - February 9 in the following calendar year. After the expiration of the time limit, the beneficiary requested payment for 2 days of inpatient hospital services furnished at hospital B during the period November 26 – 28 in the original calendar year. Although the untimely request for payment for 2 days did not result in charging the 2 days against his utilization record, it did reveal that the stay in hospital C was in the same benefit period as the stay in A. Thus, assuming that lifetime reserve days were previously exhausted, only 15 days of coverage were available for the stay in hospital C and overpayment was made for the remaining l0 days of the stay.

Do not collect any overpayment from either the beneficiary or provider based on the continuation of a benefit period that was revealed when the beneficiary filed a late request for payment as illustrated in the example above, unless evidence shows that the overpayment was the result of fraud or similar fault. (See §3709.) Collection of such an overpayment would be inequitable since it would impose another penalty because of the late filing, in addition to the denial of the late bill.

Since corrected bills are required in such overpayment cases, assure that the provider does not have the overpayment recouped in the cost settlement.

Restrictions on Provider Conditions for Admission

3313. WAIVER OF HEALTH INSURANCE BENEFITS AS CONDITION OF ADMISSION

It is not permissible for a provider to require as a condition of admission or treatment that a patient agree to waive his/her right to have provider services paid for under Medicare. Requiring such a waiver is inconsistent with the provider's contract with CMS, and the waiver is not binding on the patient. Each participating provider agrees not to charge an individual (except for specified deductible and coinsurance amounts) for services for which such individual is entitled to have payment made or for which he/she would be so entitled if the provider complied with the procedural and other requirements of the program. Further, under this provision, the provider must refund any amounts incorrectly collected.

Where a patient who has signed a waiver nevertheless requests payment under the health insurance program, the provider must bill the intermediary for the services and refund any payments made by the patient or on his/her behalf in excess of the permissible charges.

3314. RULES GOVERNING CHARGES TO BENEFICIARIES

A. General.--Under a provider's participation agreement, it may charge a beneficiary only applicable deductible and coinsurance amounts and for noncovered services. Additional restrictions and requirements covered by or based on the provider agreement regarding what a provider may collect or seek to collect from a beneficiary (or any party acting on the beneficiary's behalf) are set forth below. The provider must refund amounts incorrectly collected.

B. Requirements and Requests for Deposits and Other Payments.--A provider may not require as a condition for admission, continued care, or other provision of services, nor may the provider request or accept a deposit or other payment from a Medicare beneficiary except as follows:

o A provider may request and accept payment for a Part A deductible and coinsurance amount on or after the day to which it applies and payment for a Part B deductible and coinsurance amount at the time of or after the provision of the service to which it applies.

o A provider may require, request, and accept a deposit or other payment for services if it is clear that the services are not covered by Medicare. See subsection C for the effect of a beneficiary request for submission of a demand bill by an SNF. See subsection D for beneficiary request for submission of a demand bill (or similar request for a coverage determination) by other types of providers. See subsection E for charges for personal comfort and convenience services.

C. Effect of SNF Submission of Demand Bill.--If a SNF believes that a beneficiary requires only a noncovered level of care beginning with admission or at some point thereafter, it gives the beneficiary proper notice to that effect. If the beneficiary disagrees and asks the SNF to submit a demand bill to you, the SNF may not require, request, or accept a deposit or other payment from the beneficiary for the services until you make an initial determination that the services are not covered.

EXCEPTION: An SNF may request and accept payment for a potential Part A coinsurance amount on or after the day to which the coinsurance applies if the services are found to be covered.

If the SNF believes that the services are noncovered for reasons other than the level of care required to be furnished by the SNF (e.g., the 3-day prior hospitalization requirement is not met, the beneficiary is not admitted to the SNF within 30 days (or longer period, if appropriate) of discharge from the hospital, or SNF benefits are exhausted), the SNF must still submit a demand bill upon request. The SNF may require, request, and accept a deposit or other payment from the beneficiary for the services (in line with its usual practice for private pay patients) while your determination is pending.

D. Effect of Submission of Demand Bill by Provider Other Than SNF.--If a provider other than an SNF believes that the beneficiary requires only a noncovered level of care beginning with admission, start of care, or some point thereafter, it gives the beneficiary proper notice to that effect. If the beneficiary disagrees and asks the provider to submit a demand bill or requests PRO review, as appropriate, the provider may generally require, request, and accept a deposit or other payment from the beneficiary for services (in line with its usual practice for private pay patients) while the intermediary or PRO determination is pending. The provider must make a refund if the services are found to be covered.

EXCEPTION: If a hospital, with the concurrence of the attending physician, determines that a beneficiary who was admitted for a covered stay no longer requires inpatient hospital services, it issues a notice to this effect to the beneficiary. If the beneficiary disagrees with the determination and while still in the hospital

makes a request for review to the PRO, by phone or in writing, by noon of the first workday after receiving the hospital notice of noncoverage, the beneficiary may be charged beginning noon of the day after the day the beneficiary receives the PRO's determination of noncoverage. This provision is described in further detail in the PRO Manual.

If a provider believes that the required services are noncovered for reasons other than the level of care required, the provider must still submit a demand bill on request but may charge the beneficiary for services while the intermediary determination is pending. However, see §3610.1G for restrictions on PPS hospital charges for preentitlement and postexhaustion of benefits days.

E. Charges for Noncovered Services.--A provider may charge a beneficiary for noncovered personal comfort and convenience items (e.g., rental of a television set or the customary charge differential for a private room which is not medically necessary) if the beneficiary requests these items and services with knowledge of the charges. Also, a provider may require an advance deposit from the beneficiary for the noncovered items and services requested by the beneficiary if this is its practice with non-Medicare patients. The provider may not, however, require a beneficiary to request such noncovered items and services as a condition for admission or continued care.

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CHAPTER VII

BILL REVIEW

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Any hospital removed from PIP that has notified you of its intention to submit additional Medicaid data, or which submitted data with its request, will remain off PIP pending your evaluation of the data.

Consult your RO for specific timeframes involved, and subsequent actions required where you permit PIP for a hospital not on the listing.

For rural hospitals to continue PIP, they must be located in a rural area (as defined for PPS) and have 100 or fewer beds on July 1, 1987. A rural hospital is a hospital outside any Metropolitan Statistical Area (MSA). Use the guidelines for determining MSAs for PPS hospitals to determine whether a hospital is rural.

In determining the bed count for rural hospitals, count only beds that are general routine or intensive care type, adult or pediatric, maintained in a patient care area for inpatient lodging. Do not count beds assigned to newborns, to custodial or domiciliary care, to units excluded from PPS, to hospital based SNFs, to areas maintained and utilized for only a portion of a patient's stay, or primarily for special procedures (e.g., labor rooms, birthing rooms, postanesthesia and postoperative recovery rooms, outpatient areas or emergency rooms, or ancillary departments).

Where hospitals have significant cash flow problems as a result of removal from PIP, accelerated payments are payable in accordance with §2412 of the Provider Reimbursement Manual.

If the provider previously elected PIP and continues to qualify, continue PIP for:

- Inpatient services from hospitals other than subsection (d) hospitals;
- Hospitals which receive payment under a State hospital payment system under §1814(b)(3) or §1886(c) of the Act, if payment on a PIP basis is approved by CMS as an integral part of such payment system;
- SNF services; or
- Home health services furnished on or before September 30, 2000. (The Balanced Budget Act of 1997 eliminated PIP for home health agencies upon the implementation of the HH PPS effective October 1, 2000.)

In addition, upon request you can implement PIP effective July 1, 1987 or later for hospices meeting the requirements to qualify for PIP.

8. Receipt Date.--The receipt date is the date you receive a claim subject to the qualifications in subsection C and in §3600.2 regarding whether the data are sufficiently complete to qualify as a claim. The receipt date is used to calculate interest payments when due for clean claims, to report statistical data on claims to CMS, such as in workload reports, and to determine if a claim was received timely.

9. Scheduled Payment Date.--The scheduled payment date is the date the check you issued is mailed, deposited by you in the provider's account, or transferred electronically. For PIP claims and no payment bills, the scheduled payment date is the date for payment bills in the same adjudication batch.

B. Systems Requirements.--

1. Determine Whether You May Remove Hospitals From PIP Based on Your Processing Timeliness.--In determining whether your processing timeliness is adequate to remove hospitals from PIP, consider all clean, non-PIP bills. Select cases based upon

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4. Bills Requiring Medical Information.--When you request medical information, retain the bill as a pending record until you either pay or deny it. Returning cases for review by the PRO is not a request for medical information. Claims that fail your initial edits because required medical reports or other required attachments are not included are not requests for medical evidence.

5. Deleting Control.--Retain your control record unless deleted as described in 1, 2, 3, or 4 above until final resolution. For inpatient records which affect utilization, this is when the claim passes your final edits immediately prior to sending to CMS via UNIBILL. For other records (outpatient, HHA, SNF, etc.) it is when the claim passes your final edits immediately prior to sending to CMS via UNIBILL or a denial letter is generated.

D. Adjustment Bills.--An adjustment bill is a correction to a claim previously processed. Establish a control record for it.

Count hospital, MSP or manual PRO adjustments as pending when received. PRO electronic adjustments are received and pending only when they pass your edits. (See §3674.6.)

Assign the date received in your mailroom as the receipt date for hospital and MSP adjustments. On PRO adjustments, assign the later of the date you receive the request (passed your edits) or the date the batch clearance record was received from CMS for the claim to be adjusted.

Count adjustment bills as processed when no further action by you is required. The final action taken on the adjustment bill depends upon the situation. If an adjustment bill involves only money adjustments (no utilization changes) and will not be submitted to CMS, count it as "processed" after review and adjustment in payment. If an adjustment bill involves utilization changes and the original bill was accepted by CMS, consider it processed when submitted via UNIBILL.

3600.2 Time Limitations for Filing Provider Claims.--

Medicare regulations at 42 CFR 424.44 define the timely filing period for Medicare fee-for service claims. In general, such claims must be filed on, or before, December 31 of the calendar year following the year in which the services were furnished. (See section G below for details of the exceptions.) Services furnished in the last quarter of the year are considered furnished in the following year; i.e., the time limit is the second year after the year in which such services were furnished.

A. Determining Start Date of Timely Filing Period--Service Date.--Medicare determines the date services were furnished from dates submitted by the provider on the claim. For certain claims for services which require the reporting of a line item date of service, that line item date is used. For other claims, the claim statement covers “From” is used. What constitutes a claim and what constitutes filing are defined below.

The table that follows illustrates the timely filing limit for dates of service in each calendar month.

Table: Usual Time Limit

Date of service in:	Jan	Feb	Mar	Apr	May	June
Timely filing date	Dec 31: Service year plus 1 year	Dec 31: Service year plus 1 year	Dec 31: Service year plus 1 year	Dec 31: Service year plus 1 year	Dec 31: Service year plus 1 year	Dec 31: Service year plus 1 year
Months to file *	23	22	21	20	19	18

Date of service in:	July	Aug	Sep	Oct	Nov	Dec
Timely filing date	Dec 31: Service year plus 1 year	Dec 31: Service year plus 1 year	Dec 31: Service year plus 1 year	Dec 31: Service year plus 2 years	Dec 31: Service year plus 2 years	Dec 31: Service year plus 2 years
Months to file *	17	16	15	26	25	24

* "Months to file" represents the number of full months plus the remainder of the sevice month.

B. Definition of Claim.--Medicare regulations at 42 CFR 424.5 describe basic conditions for Medicare payment. These regulations at (5) and (6) define a claim as a filing from a provider, supplier or beneficiary that includes or refers to a beneficiary's request for Medicare payment and furnishes the Medicare contractor with sufficient information to determine whether payment of Medicare benefits is due and to determine the amount of payment. Institutional claims are in all cases filings by the provider and issues of assigned or non-assigned claims do not apply.

Medicare regulations at 42 CFR 424.32 defines the basic requirements for claims for payment. Specifically, 42 CFR 424.32 (a) (1) states, "A claim must be filed with the appropriate intermediary or carrier on a form prescribed by CMS in accordance with CMS instructions." Therefore, this regulation sets out three distinct conditions that must be satisfied in order for a provider submission to be considered a claim—it must be filed with the appropriate Medicare contractor, it must be filed on the prescribed form and it must be filed in accordance with all pertinent CMS instructions. The sections below define each of these conditions in greater detail.

1. Appropriate Medicare Contractor.--Submissions for services provided by institutions must be filed with a Medicare Fiscal Intermediary. It is the provider's responsibility to submit each claim to the appropriate contractor. Medicare contractors may attempt to re-route claims appropriately if they have enough information to do so. In the case of re-routed claims, services submitted for payment for institutional services to Medicare carriers are not considered claims under Medicare regulations until received by the appropriate Fiscal Intermediary.

2. Form Prescribed by CMS.--Regulations at 42 CFR 424.32 (b) prescribe the claim forms that must be used in terms of paper forms. The paper form prescribed for institutional providers is Form CMS-1450, also known as the UB-92 uniform billing form. However, the Administrative Simplification Compliance Act mandated the electronic submission of all Medicare claims received on or after October 16, 2003 , with a very limited number of exceptions as defined in regulations. Even prior to this mandate, the overwhelming majority of Medicare claims were submitted in electronic formats, so the electronic format equivalent to the paper form is key to determining the prescribed form used in a submission.

The prescribed electronic format for Medicare institutional claims was defined by the Health Insurance Portability and Accountability Act as the 837 institutional claim transaction as defined by the American National Standards Institute Accredited Standards Committee X12. Services submitted for payment by institutional providers on a format other than the 837 institutional claim, or its paper equivalent in the limited case where applicable, are not considered claims under Medicare regulation. Claims submitted on paper forms are entered into Medicare's electronic claims processing system and converted into electronic records in order to be processed. After the point of entry into the electronic system, handling of claims submitted on the prescribed electronic format and on its paper equivalent is identical with regard to determining timely filing.

3. In Accordance with CMS Instructions.--CMS instructions for submitting institutional claims to Medicare are contained in Chapter VII, Bill Review, and these instructions are reproduced in the billing chapters of Medicare's various provider specific manuals. To varying degrees, the instructions may be adapted and expanded to meet the needs of the Medicare provider audience when they appear in provider specific manuals, such as the Medicare Hospital Manual (CMS Publication 10) or Medicare Home Health Agency Manual (CMS Publication 11).

General instructions that reflect guidance on the use of the paper UB-92, as established by the National Uniform Billing Committee, are found in §3604. These instructions apply to all institutional claim types. These general instructions are supplemented by additional sections in the MIM and in the provider specific manuals which detail the required information for specific types of claims. In order to constitute a Medicare claim, services submitted for payment must be entered in a claim format in accordance with these instructions. Services submitted for payment in a manner not complete and consistent according to these instructions will not be accepted into Medicare's electronic claims processing system and will not be considered filed for purposes of determining timely filing.

a. Incomplete or Invalid Submissions-- Services not submitted in accordance with CMS instructions include:

-- Incomplete Submissions - Any submissions missing required information (e.g., no provider name).

-- Invalid submissions - Any submissions that contains complete and required information; however, the information is illogical or incorrect (e.g., incorrect HIC#, invalid procedure codes) or does not conform to required claim formats.

The following definitions may be applied to determine whether submissions are incomplete or invalid:

-- Required - Any data element that is needed in order to process the submission (e.g., Provider Name).

-- Not Required - Any data element that is optional or is not needed in order to process the submission (e.g., Patient's Marital Status).

-- Conditional - Any data element that must be completed if other conditions exist (e.g. if there is insurance primary to Medicare, then the primary insurer's group name and number must be entered on a claim). If these conditions exist, the data element becomes required.

Submissions that are found to be incomplete or invalid are returned to the provider (RTP). The incomplete or invalid information is detected by the FI's claims processing system. The electronic submission is returned to the provider of service electronically, with notation explaining the error(s). Assistance for making corrections is available in the on-line processing system (Direct Data Entry) or through the FI. In the limited cases where paper submission are applicable, paper submissions found to be imcomplete or invalid prior to or during entry into the contractor's claims processing system are returned to the provider of service by mail, with an attached form explaining the error(s).

The electronic record of claims which are RTP are held in a temporary storage location in the intermediary's claims processing system. The records are held in this location for a period of time that may vary among intermediaries, typically 60 days or less. During this period, the provider may access the electronic record and correct it, enabling the submission to be processed by the intermediary. If the incomplete or invalid information is not corrected within the temporary storage period, the electronic record is purged by the intermediary. There is no subsequent audit trail or other record of the submission being received by Medicare. These submissions are never reflected on a remittance advice. No permanent record is kept of the submissions because they are not considered claims under Medicare regulation.

b. Handling Incomplete or Invalid Submissions.--The following provides additional information detailing submissions which are considered incomplete or invalid.

The matrix at Appendix L specifies whether a data element is required, not required, or conditional. (See definitions in B above.) The status of these data elements will affect whether or not an incomplete or invalid submission (hardcopy or electronic) will be returned to provider (RTP). Do not deny claims and afford appeal rights for incomplete or invalid information as specified in this instruction. (See §3605.1 for Definitions.)

Intermediaries should take the following actions upon receipt of incomplete or invalid submissions:

-- If a required data element is not accurately entered in the appropriate field, RTP the submission to the provider of service.

-- If a not required data element is accurately or inaccurately entered in the appropriate field, but the required data elements are entered accurately and appropriately, process the submission.

-- If a conditional data element (a data element which is required when certain conditions exist) is not accurately entered in the appropriate field, RTP the submission to the provider of service.

-- If a submission is RTP for incomplete or invalid information, you must, at a minimum, notify the provider of service of the following information:

-- Beneficiary's Name;
-- Health Insurance Claim (HIC) Number;
-- Statement Covers Period (From-Through);

-- Patient Control Number (only if submitted);
-- Medical Record Number (only if submitted); and
-- Explanation of Errors.

NOTE: Some of the information listed above may in fact be the information missing from the submission. If this occurs, include what is available.

-- If a submission is RTP for incomplete or invalid information, you must not report the submission on the Medicare Summary Notice (MSN) to the beneficiary. The notice must only be given to the provider or supplier.

The matrix in Addendum L specifies data elements which are required, not required, and conditional. These standard data elements are minimal requirements. A crosswalk is provided to relate CMS-1450 (UB-92) form locators used on paper submissions with loops and data elements on the ASC X12 837 Institutional Claim used for electronic submissions.

The matrix does not specify loop and data element content and size. Refer to the implementation guide for the current HIPAA standard version of the 837 Institutional Claim for these specifications. If a claim fails edits for any one of these content or size requirements, RTP the submission to the provider of service.

NOTE: The data element requirements in the matrix may be superceded by subsequent CMS Program Memoranda or manual issuances. The CMS is continuously revising the manuals to accommodate new data element requirements. The matrix will be updated as frequently as annually to reflect revisions to other sections of the manual.

Intermediaries must provide a copy of the matrix listing the data element requirements, and attach a brief explanation to providers and suppliers.

Intermediaries must educate providers regarding the distinction between submissions which are not considered claims, but which are returned to provider (RTP) and submissions which are accepted by Medicare as claims for processing but are not paid. Claims may be accepted as filed by Medicare systems but may be rejected or denied. Unlike RTPs, rejections and denials are reflected on remittance advices. Denials are subject to appeal, since a denial is a payment determination. Rejections may be corrected and re-submitted.

C. Determining End Date of Timely Filing Period—Receipt Date.-- A submission, as defined above, is considered to be a filed claim for purposes of determining timely filing on the date that the submission passes edits for completeness and validity described in section B above and is accepted into Medicare adjudication processes. At this point, the submission receives a permanent receipt date which remains part of the claim record.

The receipt date has two functions. It is used for determining whether the claim was timely filed (see section D below). The same date is also used as the receipt date for purposes of determining claims processing timeliness on the part of the intermediary. (See §3600.1 for details on determining claims processing timeliness.)

D. Determination of Timely Filing and Resulting Actions -- Medicare determines a claim is filed timely only through the comparison of the date the services were furnished (line item date or claim statement "from" date) to the receipt date applied to the claim when it is accepted for adjudication. If the span between these two dates exceeds the time limitation defined in section A above, the claim is not received timely.

Reject claims not received timely. Where the beneficiary request for payment was filed timely (or would have been filed the request timely had the provider taken action to obtain a request from the patient whom the provider knew or had reason to believe might be a beneficiary) but the provider is responsible for not filing a timely claim, the provider may not charge the beneficiary for the services except for such deductible and/or coinsurance amounts as would have been appropriate if Medicare payment had been made. In appropriate cases, such claims should be processed because of the spell-of-illness implications and/or in order to record the days, visits, cash and blood deductibles. The beneficiary is charged utilization days, if applicable for the type of services received.

When a claim is received from a provider paid on a cost basis where only part of the services were filed within the timely filing period, FIs must reject the claim. The provider may resubmit the services, splitting them into two claims with discrete periods before and on or after October 1. For example, if an FI received a claim on February 3, 2002, for provider services furnished from September 16, 2000 through October 30, 2000, services furnished before October 1 are rejected because the time for filing the September services expired December 31, 2001.

This same prinicple is applied to services paid on a fee or bundled basis for which payments can be divided into discrete periods before and after October 1. However, if services spanning October 1 are subject to prospective payment bundling provisions and cannot be split in this fashion, apply the timely filing period for the fourth quarter of the calendar year to the entire claim.

E. Application to Special Claim Types --

o Adjustments.--If a provider fails to include a particular item or service on its initial claim, an adjustment submission to include such an item(s) or service(s) is not permitted after the expiration of the time limitation for filing of the initial claim. There is no longer timely filing period for adjustments. There are special timeliness requirements for filing adjustment requests for inpatient services subject to a prospective payment system, if the adjustment results in a change to a higher weighted Diagnosis Related Group (DRG). These adjustments must be submitted within 60 days of the date of the remittance for the original claim, or the adjustment will be rejected.

However, to the extent that an adjustment bill otherwise corrects or supplements information previously submitted on a timely claim about specified services or items furnished to a specified individual, it is subject to the rules governing administrative finality, rather than the time limitation for filing (see §3799).

o Emergency Hospital Services and Services Outside the United States.--The time limit for claims for payment for emergency hospital services and hospital services outside the United States, whether or not the hospital has elected to bill the program, is the same as for participating hospitals.

(See section A above.) The claim for emergency hospital services and other services outside the United States will be considered timely filed if filed with any intermediary within the time limit.

F. Filing Claim Where Usual Time Limit Has Expired.--As a general rule, where you receives a late filed claim submitted by a provider with no explanation attached as to the circumstances surrounding the late filing, assume that the provider accepts responsibility for the late filing.

Where it comes to the attention of a provider that health services which are or may be covered were furnished to a beneficiary but that the usual time limit (defined in section A above) on filing a claim for such services has expired, the provider should take the following action.

Where the provider accepts responsibility for late filing, it should file a no-payment claim. (See §3624.) Where the provider believes the beneficiary is responsible for late filing, it should contact the intermediary and also file a no-payment claim and include a statement in the remarks field on the claim explaining the circumstances which led to the late filing and giving the reasons for believing that the beneficiary (or other person acting for him) is responsible for the late filing. If a paper claim is submitted, such a statement may be attached and, if practicable, may include the statement of the beneficiary as to the beneficiary's view on these circumstances. The intermediary annotates the claim record with nonpayment code R.

Where the provider believes Medicare or its agents are responsible for the late filing, refer to section G below regarding the administrative error exception to timely filing requirements.

Where the beneficiary does not agree with the determination that the claim was not filed timely or with the assignment to him of the responsibility for the late filing, the usual appeal rights are available to the beneficiary. Where the provider is protesting the denial of payment or the assignment of responsibility, no formal channels of appeal are available. However, the intermediary may, at the request of the provider, informally review its initial determination.

G. Exceptions Allowing Extension of Time Limit.--Medicare regulations allow only two exceptions to the timely filing requirements described above. Exceptions may be made in cases of the Medicare program's administrative error or in cases in which the provider filed a Statement of Intent (SOI) to file claims.

1. Adminstrative Error.--Medicare regulations at 42 CFR 424.44 allow that where Medicare program error causes the failure of the provider to file a claim for payment within the time limit in section A above, the time limit will be extended through the last day of the sixth calendar month following the month in which the error is rectified by notification to the provider or beneficiary. Administrative error may include misrepresentation, delay, mistake, or other action of Medicare, or its intermediaries or carriers or the Social Security Administration (SSA). Fiscal intermediaries will not submit for approval requests for extensions for such errors which extend beyond December 31 of the third calendar year after the year in which the services were furnished. (For services furnished during October - December of a year, the time limit may be extended no later than the end of the fourth year after that year.)

The administrative error which prevents timely filing of the claim may affect the provider directly or indirectly, i.e., by preventing the beneficiary or his representative from filing a timely request for payment. Situations in which failure to file within the usual time limit will be considered to have been caused by administrative error include but are not limited to the following:

- The failure resulted because the individual's entitlement to Medicare Hospital Insurance (HI) or Supplementary Medical Insurance (SMI) was not established until long after the month for which it is effective (e.g., a beneficiary is awarded 2 years of retroactive coverage).

- The failure resulted from SSA's failure to notify the individual that his entitlement to HI or SMI had been approved, or in giving him (or his representative or the provider) cause to believe that he is not entitled to HI or SMI.

- The failure resulted from misinformation from Medicare or the intermediary or carrier, e.g., that certain services were not covered under HI or SMI, although in fact they were covered.

- The failure resulted from excessive delay by Medicare, the intermediary, or the carrier in furnishing information necessary for the filing of the claim.

- The failure resulted from advice by Medicare or an authorized agent from Medicare that precluded the filing of a claim until the provider receives certain information from the intermediary (e.g., a hospital following manual instructions does not file a billing for outpatient services where the services are expected to be paid for by workmen's compensation; but the hospital learns after the expiration of the time limit of the ultimate denial of workmen's compensation liability).

Any claim involving situations other than those listed above, where it appears that an extension of the time limit might be justified on the basis of administrative error should be submitted by the intermediary with a recommendation, before payment, to the appropriate CMS Regional Office (RO). Also, any claim, whether involving the situations listed above or others, in which administrative error prevented timely filing until after the close of the third year following the year in which the services were furnished (fourth year, in the case of services furnished in the October - December quarter) should be submitted to the appropriate CMS RO for advice before denial action.

Where administrative error is alleged to be responsible for late filing, the necessary evidence would ordinarily include:

- A statement from the beneficiary, his representative or the provider, depending on whom the error directly affected, as to how he learned of the error, and when it was corrected, and one of the following:

- A written report by the agency (Medicare, SSA, carrier, intermediary) based on agency records, describing how its error caused failure to file within the usual time limit; or

- Copies of an agency letter or written notice reflecting the error; or

- A written statement of an agency employee having personal knowledge of the error.

However, the statement of the beneficiary, his representative, or the provider is not essential if the other evidence establishes that his failure to file within the usual time limit resulted from administrative error, and that he filed a claim within 6 months after the month in which he was notified that the error was corrected. There must be a clear and direct relationship between the administrative error and the late filing of the claim. Where the evidence is in the intermediary's own records, it should annotate the claims file to this effect.

Where the initial allegation of administrative error on the part of the Government is made to the servicing social security office (SS) or to the CMS Regional Office (RO), the SSO or RO will forward any necessary report, statement and/or other evidence to the intermediary and will obtain and forward a request by the beneficiary or his representative for Medicare payment if such request was not previously filed with the provider or intermediary. The intermediary will then obtain a billing from the provider if not previously submitted. At CMS' discretion, consideration of such allegations may not be limited to the 3-4 year period described above.

If an allegation that administrative error caused late filing is made to the intermediary or if the information furnished by the SSO or RO is incomplete, the intermediary will request the necessary evidence (see A above) from the SSO servicing the beneficiary. Where another carrier or intermediary allegedly caused the delay, the request for necessary information and evidence may be made by letter directly to the other carrier or intermediary.

Where covered expenses in excess of deductible and coinsurance exceed $l00 and the provider has assigned responsibility for the late filing to the beneficiary (or his representative), corroboration of such responsibility should be obtained since otherwise the beneficiary could be forced to pay

substantial charges for which he may not be liable. If the provider has not obtained a written explanation of the circumstances from the beneficiary, and there is no other corroboration of such responsibility, the intermediary should request the assistance of the SSO in obtaining it. Corroboration may be in the form of a signed statement, a report of the oral explanation given by the beneficiary (or his representative or relative) of the late filing, or pertinent information in the SSO's files.

The intermediary has the responsibility for deciding, on the basis of all pertinent circumstances, whether a late claim may be honored. The intermediary may ordinarily accept a statement from some other component which shows whether there was an administrative error which could reasonably have prevented or deterred the claimant from filing within the usual time limit. Similarly, the intermediary will ordinarily accept a statement from the component which corrected the error as to whether and when this was done. However, where information submitted to the intermediary by another component involved in HI or SMI administration is incomplete or questionable, the intermediary may request clarification. Providers whose requests for exceptions on the basis of administrative error are denied may first request review form the appropriate CMS RO and in exceptional circumstances may then a request a final review from CMS Central Office.

2. Statement of Intent.--Medicare regulations at 42 CFR 424.45 allow for the submission of written statements of intent (SOI) to claim Medicare benefits. The purpose of a SOI is to extend the timely filing period for the submission of an initial claim. A SOI, by itself, does not constitute a claim, but rather is used as a placeholder for filing a timely and proper claim. The timely filing period to file a specific Medicare claim defined in section A above may be extended when a valid SOI, with respect to that claim, is furnished to the appropriate Medicare intermediary (i.e., the one that will be responsible for processing the claim), or regional office (RO) serving the area of the beneficiary's residence within the timely filing period. After a valid SOI has been filed, a completed claim that meets the requirements defined in section B above must be submitted to the appropriate Medicare contractor within 6 months after the month in which the contractor notifies the party who submitted the SOI that a claim may be filed, or by the end of the applicable timely filing period, whichever is later. Detailed instructions regarding the submission requirements for SOI are published in Medicare Program Memoranda.

3. Reopening of Determinations.--Medicare determinations regarding timely filing of claims, like other Medicare final determination made on a claim for payment, may occasionally be subject to reopening and revision. See §3799 for instructions regarding reopenings.

3600.3 Reviewing Bills for Services After Suspension, Termination, Expiration, or Cancellation of Provider Agreement, or After a SNF is Denied Payment for New Admissions.--See §3008.4 for provisions for payment following a termination, expiration, or cancellation of a provider agreement. Effective August 1986, a SNF may be denied payment for new admissions as an option to termination of its provider agreement for noncompliance with one or more conditions of participation. The SNF may only be reimbursed for covered services furnished on or after the effective date of denial of payments if such services were furnished to beneficiaries who were admitted to the SNF before the effective date payments were denied

EXAMPLE: Effective date of denial of payment - 9-30-86
Beneficiary admitted before 9-30-86 - pay for covered Part A or B services
Beneficiary admitted on or after 9-30-86 - deny payment under Part A or B

NOTE: An inpatient who goes on leave from the SNF before or after the effective date of denial of payments for new admissions is not considered a new admission when returning from leave.

You are notified of SNF payment denials through the CMS-2007. Install appropriate edits or other safeguards to prevent incorrect payments to the provider.

Obtain a list of Medicare inpatients when a SNF or hospital agreement is terminated, or after a SNF is denied payment for new admissions to assure that nonpayment spell of illness bills are filed. (See §3604, Item 24.)

Following termination, expiration, or cancellation of its agreement, a hospital or SNF is considered to be a "nonparticipating provider." An inpatient of such an institution who has Part B coverage, but for whom Part A benefits have been exhausted or otherwise not available, is entitled to reimbursement only for services that are covered in a nonparticipating institution. A patient admitted to the SNF on or after the effective date of denial of payment who has Part B coverage is entitled to reimbursement for services covered in a nonparticipating institution. Such services furnished on or after the effective date of termination, or in the case of expiration or cancellation of an SNF agreement, on or after the day following the close of such agreement, are billed on Form CMS-l500, Health Insurance Claim Form and sent to the carrier.

A terminated hospital may be certified to provide emergency services. If it meets the criteria, it is assigned an emergency provider number (E suffix). This procedure is not automatic, and hospitals terminated for Life Safety Code violations may not be able to qualify. If a terminated hospital qualifies, billings are handled by the designated emergency intermediary.

In a no-payment situation, where the entire billing period represents charges for which no Part A payment can be made, it is not necessary to submit two bills. Submit only a final no-payment bill, with a discharge date, under the former provider number.

Services furnished during the "no-payment" period may subsequently be determined to be covered. Where such covered services were furnished before the date of change in provider number, the provider submits one corrected bill covering the entire period showing the former provider number. Where the services were furnished after the date of change in provider number or both before and after the date of change, the provider submits a corrected discharge bill.

3600.4 Change of Intermediary.--The RO sends the official notice to you of changes in your list of providers. (See Part 2, §28l0.) The following special procedures apply:

A. Outgoing Intermediary is Still Connected with Medicare Program.--Non-PPS providers and excluded units submit interim bills to the outgoing intermediary for services and supplies furnished prior to the date of change. Bills for services and supplies furnished beginning with the effective date of change are submitted to the new intermediary. Each intermediary updates CMS utilization records based upon the bill it processes.

When an intermediary change occurs, CMS does not require a new admission query. The established admission remains on CMS's records until a final bill is accepted.

PPS hospitals do not submit separate bills. The incoming intermediary is billed for the entire stay upon the beneficiary's discharge.

B. Outgoing Intermediary is Not Connected with Medicare.--Where the prior intermediary is no longer connected with the Medicare program, it may be necessary for the new intermediary to handle bills which it normally would not process. Where the outgoing intermediary is terminating participation, the RO makes the necessary arrangements to effect a smooth transition.

3600.5 Multiple Provider Numbers or Changes in Provider Number.--Where a multiple facility provider is assigned separate provider numbers for each facility or where it is assigned a different number, special billing procedures are necessary. The provider uses the new number for all bills, beginning with the date the new number takes effect.

It submits a bill with the old provider number for the period before the change and another with the new provider number for the period after the change. The date of discharge on the first bill and the date of admission on the second bill are the same, i.e. the effective date of the new provider number. All subsequent billings are submitted under the new provider number.

3873.2 Bill Type Codes and allowable Provider Numbers.-- See §§ 3876.1 and 3878 for the codes listed by record layout. See also State Operations Manual § 2779 for definitions of facility types.

Bill Type Code	Provider Number Range(s)
11X Hospital Inpatient (Part A)	0001-0879, 1225-1299, 2000-2299, 3025-3099, 3300-3399, 4000-4499, S001-S999, T001-T999
12X Hospital Inpatient Part B	Same as 11X
13X Hospital Outpatient	Same as 11X
14X Hospital Other Part B	Same as 11X
18X Hospital Swing Bed	U001-U999, W001-W999, Y001-Y999, Z001-Z999
21X SNF Inpatient	5000-6499
22X SNF Inpatient Part B	5000-6499
23X SNF Outpatient	5000-6499
28X SNF Swing Bed	5000-6499
32X Home Health	7000-7999, 8000-8499, 9000 -9499
33X Home Health	7000-7999, 8000-8499, 9000 -9499
34X Home Health (Part B Only)	7000-7999, 8000-8499, 9000 -9499
41X Religious Nonmedical Health Care Institutions	1990-1999
71X Clinic Rural Health	3400-3499, 3800-3999, 8500-8999
72X Clinic ESRD	2300-2999, 3500-3799
73X Federally Qualified Health Centers	1800-1989
74X Clinic OPT	6500-6989
75X Clinic CORF	3200-3299, 4500-4599, 4800-4899
76X Community Mental Health Centers	1400-1499, 4600-4799, 4900-4999
81X Non-hospital based hospice	1500-1799
82X Hospital based hospice	1500-1799
83X Hospital Outpatient (ASC)	Same as 11X
85X Critical Access Hospital	1300-1399

		ADDENDUM L												
Part A -- Paper and Electronic Data Requirements														
Data Elements														
EMC	**Paper**													
Loop:Segment:	**Form**		**HOSP**							**SNF**				
Element*	**Locator**	**Data Elements Description**	**I**	**O**	**H**	**C/OP**	**RH/FQ**	**HH**	**RD**	**I**	**O**	**RN**		
2010AA all segments	1	Provider Name, Address, Phone #	R	R	R	R	R	R	R	R	R	R		
n/a	2	Untitled	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR		
2300:CLM01	3	Patient Control Number	R	R	R	R	R	R	R	R	R	R		
2300:CLM05	4	Type of Bill	R	R	R	R	R	R	R	R	R	R		
2010AA:NM108	5	Federal Tax Number	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR		
2300:DTP03:434 qualifier	6	Statement Covers Period (from-through)	R	R	R	R	R	R	R	R	R	R		
2300:QTY01:CA qualifier	7	Covered Days	R	NR	NR	NR	NR	NR	NR	R	NR	R		
2300:QTY01:NA qualifier	8	Noncovered Days	R	NR	NR	NR	NR	NR	NR	R	NR	R		
2300:QTY01:CD qualifier	9	Coinsurance Days	R	NR	NR	NR	NR	NR	NR	C	NR	C		
2300:QTY01:LA qualifier	10	Lifetime Reserve Days	R	NR	NR	NR	NR	NR	NR	C	NR	C		
n/a	11	Untitled	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR		
2010CA:NM103:QC qualifier	12	Patient's Name	R	R	R	R	R	R	R	R	R	R		
2010CA:N301	13	Patient's Address	R	R	R	R	R	R	R	R	R	R		
2010CA:DMG02:D8 qualifier	14	Patient's Birthdate	R	R	R	R	R	R	R	R	R	R		
2010CA:DMG03:D8 qualifier	15	Patient Sex	R	R	R	R	R	R	R	R	R	R		
not used	16	Patient's Marital Status	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR		
2300:DTP03:435 qualifier	17	Admission Date	R	NR	R	NR	NR	R	NR	R	NR	R		
2300:DTP03:435 qualifier	18	Admission Hour	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR		
2300:CL101	19	Type of Admission	R	NR	NR	NR	NR	NR	NR	R	NR	R		
2300:CL102	20	Source of Admission	R	R	NR	NR	NR	R	NR	R	NR	R		
2300:DTP03:096 qualifier	21	Discharge Hour	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR		
2300:CL103	22	Patient Status	R	R	R	NR	NR	R	NR	R	R	R		
2300:REF02:EA qualifier	23	Medical Record Number	C	C	C	C	C	C	C	C	C	C		
2300:HI01:BG qualifier	24-30	Condition Codes	C	C	C	C	C	C	C	C	C	C		
n/a	31	Untitled	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR		
2300:HI01:BH	32-35	Occurrence Codes and Dates	C	C	C	C	C	C	C	C	C	C		
2300:HI01:BI	36	Occurrence Span Code and Dates	C	C	C	C	C	C	C	C	C	C		

		ADDENDUM L												
Part A -- Paper and Electronic Data Requirements														
Data Elements														
EMC Loop:Segment: Element*	**Paper Form Locator**		**HOSP**							**SNF**				
		Data Elements Description	**I**	**O**	**H**	**C/OP**	**RH/FQ**	**HH**	**RD**	**I**	**O**	**RN**		
2300:REF02:F8 qualifier	37	Internal Control # (ICN)/Document Control # (DCN)	C	C	C	C	C	C	C	C	C	C		
2010BD all segments	38	Responsible Party Name and Address	C	C	C	C	C	C	C	C	C	C		
2300:HI01:BE qualifier	39-41	Value Codes and Amounts	C	C	C	C	C	C	C	C	C	C		
2400:SV201	42	Revenue Code	R	R	R	R	R	R	R	R	R	R		
n/a	43	Revenue Description	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR		
2400:SV202	44	HCPCS/HIPPS/Rates	C	C	C	C	C	C	C	C	C	C		
2400:DTP03	45	Service Date	NR	C	C	C	C	C	C	NR	C	C		
2400:SV205	46	Service Units	R	R	R	R	R	R	R	R	R	R		
2400:SV203	47	Total Charges	R	R	R	R	R	R	R	R	R	R		
2400:SV207	48	Noncovered Charges	C	C	C	C	C	C	C	C	C	C		
n/a	49	Untitled	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR		
2010BC:NM103	50	Payer Identification	R	R	R	R	R	R	R	R	R	R		
2010AA:REF01:1A qualifier	51	Provider Number	R	R	R	R	R	R	R	R	R	R		
2300:CLM09	52	Release of Information	R	R	R	R	R	R	R	R	R	R		
2300:CLM08	53	Assignment of Benefits Certification Indicator	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR		
2300:AMT02:C5 qualifier	55	Estimated Amount Due	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR		
n/a	56	Untitled	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR		
n/a	57	Untitled	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR		
2010AA:NM103:IL qualifier	58	Insured's Name	R	R	R	R	R	R	R	R	R	R		
2320:SBR02	59	Patient's Relationship to Insured	C	C	C	C	C	C	C	C	C	C		
2010:NM109	60	Certificate/Social Security #/HI Claim/Identification #	R	R	R	R	R	R	R	R	R	R		
2320:SBR04	61	Group Name	C	C	C	C	C	C	C	C	C	C		
2000:SBR02	62	Insurance Group Number	C	C	C	C	C	C	C	C	C	C		
2300:REF02	63	Treatment Authorization Number	NR	NR	NR	NR	NR	R	NR	NR	NR	NR		
2320:SBR01	64	Employment Status Code	C	C	C	C	C	C	C	C	C	C		
2320:SBR01	65	Employer Name	C	C	C	C	C	C	C	C	C	C		

		ADDENDUM L												
Part A -- Paper and Electronic Data Requirements														
Data Elements														
EMC	**Paper**													
Loop:Segment:	**Form**		**HOSP**							**SNF**				
Element*	**Locator**	**Data Elements Description**	**I**	**O**	**H**	**C/OP**	**RH/FQ**	**HH**	**RD**	**I**	**O**	**RN**		
2320:SBR01	66	Employer Location	C	C	C	C	C	C	C	C	C	C		
2300:HI01:BK qualifier	67	Principal Diagnosis Code	R	R	R	R	R	R	R	R	R	NR		
2300:HI01:BF qualifier	68-75	Other Diagnosis Codes	C	C	C	C	C	C	C	C	C	NR		
2300:HI02:BJ qualifier	76	Admitting Diagnosis	R	NR	NR	NR	NR	NR	NR	R	NR	NR		
2300:HI03:BN qualifier	77	E-Code	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR		
n/a	78	Untitled	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR		
n/a	79	Procedure Coding Method	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR		
2300:HI01:BP qualifier	80	Principal Procedure Code	C	NR	NR	NR	NR	NR	NR	NR	NR	NR		
2300:HI01:BO qualifier	81	Other Procedure Codes and Dates	C	NR	NR	NR	NR	NR	NR	NR	NR	NR		
2310A:NM101:71 qualifier	82	Attending/Referring Physician I.D.	R	R	R	R	R	R	R	R	R	NR		
2310B:NM103:72 qualifier	83	Other Physician I.D. (1)	C	C	C	C	C	NR	C	C	C	NR		
2310C:NM103:73 qualifier	83	Other Physician I.D. (2)	C	C	C	C	C	NR	C	C	C	NR		
2010:N301	84	Remarks	C	C	C	C	C	C	C	C	C	C		
n/a	85	**Provider Representative Signature	R	R	R	R	R	NR	R	R	R	R		
n/a	86	**Date	R	R	R	R	R	NR	R	R	R	R		
* -- Includes qualifier if segment and element are repeated in the same loop														
** -- Required only for hardcopy														
KEY:														
R=Required; NR=Not required; C=Conditional														
These indicators represent Medicare requirements only. Additional data elements may be required by the 837 claim implementation guide.														
Hospital: I=Inpatient and O=Outpatient; H=Hospice; C/OP=CORF/CMHC/Outpatient Physical Therapy														
RH/FQ=Independent Rural Health Clinics/Free--Standing Federally Qualified Health Centers														
HH=Home Health Agency; RD=Renal Dialysis Facility (Non-Hospital Operated)														
Skilled Nursiing Facility: I=Inpatient and O=Outpatient; RN=Religious Nonmedical Health Care Institution														