Medicare Claims Processing Manual

Chapter 1 - General Billing Requirements

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(Rev. 1706, 03-27-09)
(Rev. 1707, 03-27-09)

01 - Foreword

(Rev. 980, Issued: 06-14-06, Effective: 10-01-06, Implementation: 10-02-06)

Generally, this chapter describes policy applicable to Medicare fee-for-service claims, or what is known as the original or traditional Medicare program. See the Medicare Managed Care Manual for services to enrollees in managed care plans.

Unless specified otherwise the instructions in this chapter apply to both providers and suppliers, and to the contractors that process their claims.

In this chapter the terms provider and supplier are used as defined in 42 CFR 400.202.

- Provider means a hospital, a CAH, a skilled nursing facility, a comprehensive outpatient rehabilitation facility, a home health agency, or a hospice that has in effect an agreement to participate in Medicare, or a clinic, a rehabilitation agency, or a public health agency that has in effect a similar agreement but only to furnish outpatient physical therapy or speech-language pathology services, or a community mental health center that has in effect a similar agreement but only to furnish partial hospitalization services.
- Supplier means a physician or other practitioner, or an entity other than a provider that furnishes health care services under Medicare. A supplier must meet certain requirements and enroll as described in Chapter 10 of the Medicare Program Integrity Manual. A provider that meets the applicable conditions may also enroll as a supplier of a particular service and may bill separately for that service where Medicare payment policy allows separate payment for the service.

10 - Jurisdiction for Claims

(Rev. 1, 10-01-03)

In general FIs have jurisdiction for providers and institutional suppliers. Examples of institutional suppliers are renal dialysis facilities, comprehensive outpatient rehabilitation facilities, rural health clinics, and federally qualified health centers. In general, carriers have jurisdiction for physicians and other individual practitioners, and for labs that are not a part of hospital, ambulance suppliers, ASCs, DME suppliers, and IDTFs.

See §§10.1 - 10.2 for more detail.

10.1 - Carrier Jurisdiction of Requests for Payment

(Rev. 1, 10-01-03)

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Carriers have jurisdiction for all claims from the following:

- Physicians;
- Other individual practitioners;
- Groups of physicians or practitioners;
- Labs not part of a hospital;
- Ambulance claims submitted by ambulance companies under their own Medicare number (hospitals may operate ambulances as part of the hospital and bill the intermediary (FI));

- Ambulatory surgical centers (ASCs); and
- Independent diagnostic testing facilities (IDTFs).

Durable medical equipment regional carriers (DMERCs) have jurisdiction for claims from the following:

- Nonimplantable durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) (including home use);
- Suppliers of enteral and parenteral products other than to inpatients covered under Part A;
- Oral drugs billed by pharmacies; and
- Method II home dialysis.

The CMS maintains a list of which HCPCS codes are under DMERC jurisdiction and which are area carrier jurisdiction, and issues updates to DMERCs and carriers as needed.

There are four DMERCs each of which is assigned specific States.

Medicare area carriers typically process Part B fee-for-service claims for services furnished in specific geographic areas (e.g., a State). However a single carrier processes all physician/supplier claims for railroad retirement beneficiaries. . (See §10.1.3 for claims for Part B medical services performed outside the U.S. for individuals who reside in the U.S.).

The rules for determining jurisdiction are the same whether a claim is assigned or nonassigned (see §30.3 for assignment rules).

Further information on carriers for specific geographic areas is available on the CMS Web site at http://www.cms.hhs/contacts/incardir.asp.

Most skilled nursing facilities submit claims to the FI. However, a nonparticipating skilled nursing facility (SNF) is considered a supplier and its claims are submitted to the appropriate carrier under its own Medicare supplier number.

10.1.1 - Payment Jurisdiction Among Local Carriers for Services Paid Under the Physician Fee Schedule and Anesthesia Services

(Rev. 1193, Issued: 03-09-07; Effective: 10-01-07; Implementation: 10-01-07)

The jurisdiction for processing a request for payment for services paid under the Medicare Physician Fee Schedule (MPFS) and for anesthesia services is governed by the payment locality where the service is furnished and will be based on the ZIP code. Though a number of additional services appear on the MPFS database, these payment jurisdiction rules apply only to those services actually paid under the MPFS and to anesthesia services. (For example, it does not apply to clinical lab, ambulance or drug claims.)

Effective for claims received on or after April 1, 2004, carriers must use the ZIP code of the location where the service was rendered to determine carrier jurisdiction over the claim and the correct payment locality. Effective for dates of service on or after October 1, 2007, except for services provided in POS "Home," if they are not already doing so, contractors shall use the CMS zip code file along with the zip code submitted on the claim with the address that represents where the service was performed to determine the correct payment locality. (See section 10.1.1.1 for instructions on when a 9-digit ZIP code is required.)

When a physician, practitioner, or supplier furnishes physician fee schedule or anesthesia services in payment localities that span more than one carrier's service area (e.g., provider has separate offices in multiple localities and/or multiple carriers), separate claims must be submitted to the appropriate area carriers for processing. For example, when a physician with an office in Illinois furnishes services outside the office setting (e.g., home, hospital, SNF visits) and that out-of-office service location is in another carrier's service area (e.g., Indiana), the carrier which processes claims for the payment locality where the out of office service was furnished has jurisdiction for that service. It is the carrier with the correct physician fee schedule pricing data for the location where the service was furnished. In the majority of cases, the physician fee schedule or anesthesia services provided by physicians are within the same carrier jurisdiction that the physicians' office(s) is/are located.

Although pricing rules for services paid under the MPFS remain in effect, effective for claims with dates of service on or after January 25, 2005, suppliers (including laboratories, physicians, and independent diagnostic testing facilities [IDTFs]) must bill their local carrier for all purchased diagnostic tests/interpretations, regardless of the location where the purchased service was furnished. Beginning in 2005, and in each subsequent calendar year (CY) thereafter, CMS will provide carriers with a national abstract file containing Healthcare Common Procedural Coding System (HCPCS) codes that are payable under the MPFS as either a purchased test or interpretation for the year. In addition, CMS will make quarterly updates to the abstract file to add and/or delete codes, as needed, in conjunction with the MFSDB quarterly updates. As with all other services payable under the MPFS, the ZIP code of the locality in which the service was furnished determines the payment amount. Refer to §30.2.9 for the supplier billing requirements applicable to purchased diagnostic services.

A. Multiple Offices

In states with multiple physician fee schedule pricing localities or where a provider has multiple offices located in two or more states, or there is more than one carrier servicing a particular state, physicians, suppliers and group practices with multiple offices in such areas must identify the specific location where office-based services were performed. This is to insure correct claim processing jurisdiction and/or correct pricing of MPFS and anesthesia services. The carrier must ensure that multiple office situations are cross-referenced within its system. If a physician/group with offices in more than one MPFS pricing locality or a multi-carrier state fails to specify the location where an office-based service was furnished, the carrier will return/reject the claim as unprocessable.

Physicians, suppliers, and group practices that furnish physician fee schedule services at more than one office/practice location may submit their claims through one office to the carrier for processing. However, the specific location where the services were furnished must be entered on the claim so the carrier has the ZIP code, can determine the correct claims processing jurisdiction, and can apply the correct physician fee schedule amount.

B. Service Provided at a Place of Service Other than Home-12 or Office-11

For claims submitted prior to April 1, 2004, in order to determine claims jurisdiction, Medicare approved charges, Medicare payment amounts, Medicare limiting charges and beneficiary

liability, Part B fee-for-service claims for services furnished in other than in an office setting or a beneficiary's home must include information specifying where the service was provided.

Effective for claims received on or after April 1, 2004, claims for services furnished in all places of service other than a beneficiary's home must include information specifying where the service was provided. Carriers must use the address on the beneficiary files when place of service (POS) is home - 12, or any other mechanism currently in place to determine pricing locality when POS is home – 12. Carriers shall take this same action for any other POS codes they currently treat as POS home.

C. Outside Carrier Jurisdiction

If carriers receive claims outside of their jurisdiction, they must follow resolution procedures in accordance with the instructions in 10.1.9. If they receive a significant volume or experiences repeated incidences of misdirected Medicare Physician Fee Schedule or anesthesia services from a particular provider, an educational contact may be warranted.

D. HMO Claims

For services that HMOs are not required to furnish, carriers process claims for items or services provided to an HMO member over which they have jurisdiction in the same manner as they process other Part B claims for items or services provided by physicians or suppliers. Generally, the physician/supplier who provides in-plan services to its HMO members submits a bill directly to the HMO for payment and normally does not get involved in processing the claim. 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.

10.1.1.1 - Claims Processing Instructions for Payment Jurisdiction for Claims Received on or after April 1, 2004

(Rev. 1591, Issued: 09-09-08, Effective: 01-01-09, Implementation: Carriers and A/B MACs Part B Claims: analysis/design 07-07-08, design/production 10-06-08, production/implementation 01-05-09 / FIs and A/B MACs Part A Claims: analysis/design 07-07-08, coding/unit testing 10-06-08, system testing/implementation 01-05-09)

Provided below are separate instructions for processing electronic claims using the ANSI X12N 837 format and paper claims. No changes will be required in either submission or processing for claims for services subject to jurisdictional pricing for services paid under the Medicare physician fee schedule and anesthesia services submitted on the National Standard Format. See §30.2.9 and Chapter 12 for additional information on purchased tests.

A. ANSI X12N 837 P Electronic Claims

Please note that the following instructions do not apply to services rendered at POS home -12. For services rendered at POS home –12, use the address on the beneficiary file (or wherever else the beneficiary information is currently being stored) to determine pricing locality. (See §10.1.1.)

Per the implementation guide of the 4010/4010A1 version of the ANSI X12N 837 P, it is acceptable for claims to contain the code for POS home and any number of additional POS codes. If different POS codes are used for services on the claim, a corresponding service facility location and address must be entered for each service at the line level, if that location is different from the billing provider, pay-to-provider, or claim level service facility location. Pay the service based on the ZIP code of the service facility location, billing provider address, or pay-to provider address depending upon which information is provided.

Refer to the current implementation guide of the ANSI X12N 837 P to determine how information concerning where a service was rendered, the service facility location, must be entered on a claim. Per the documentation, though an address may not appear in the loop named "service facility address," the information may still be available on the claim in a related loop.

EXAMPLE: On version 4010/4010A of the ANSI X12N 837 P electronic claim format, the Billing Provider loop 2010AA is required and therefore must always be entered. If the Pay-To Provider Name and Address loop 2010AB is the same as the Billing Provider, only the Billing Provider will be entered. If no Pay-To Provider Name and Address is entered in loop 2010AB, and the Service Facility Location loop 2310D (claim level) or 2420C (line level) is the same as the Billing Provider, then only the Billing Provider will be entered. In this case, price the service based on the Billing Provider ZIP code.

EXCEPTION: For DMERC claims - Effective for claims received on or after 1/1/05, the Standard System shall not evaluate the 2010AA loop for a valid place of service. If there is no entry in the 2420C loop or the 2310D loop, the claim shall be returned as unprocessable.

- If the Pay-To Provider Name and Address loop 2010AB is not the same as the Billing Provider, both will be entered. If the Service Facility Location loop 2310D is not the same as the Billing Provider or the Pay-To Provider, the Service Facility Location loop 2310D (claim level) will be entered. Price the service based on the ZIP code in Service Facility Location loop 2310D, unless the 2420C (line level) is also entered. In that case, price the service based on the ZIP code in the Service Facility Location loop 2420C (line level) for that line.

Make any necessary accommodations in claims processing systems to accept either the header level or line level information as appropriate and process the claims accordingly. No longer use the provider address on file when the POS is office to determine pricing locality and jurisdiction. Appropriate information from the claim must always be used.

In the following situation, per the information in the 4010/4010A1 version of the ANSI X12N 837 P, the place where the service was rendered cannot be identified from the claim. In this situation, price all services on the claim based on the ZIP code in the Billing Provider loop. Continue to take this action until such time as the ASC documentation is revised to allow for identification of where the service was rendered to be identified from the claim.

If the Pay-To Provider Name and Address loop 2010AB is not the same as the Billing Provider, both will be entered. If the Service Facility Location loop 2310D (claim level) or 2420C (line level) is the same as the Billing Provider or the Pay-To Provider, no entry is required per version 4010/4010A1 for Service Facility Location loop 2310D (claim level) or 2420C (line level).

When the same POS code and same service location address is applicable to each service line on the claim, the service facility location name and address must be entered at the claim level loop 2310D.

In general, when the service facility location name and address is entered only at the claim level, use the ZIP code of that address to determine pricing locality for each of the services on the claim. When entered at the line level, the ZIP code for each line must be used.

If the POS code is the same for all services, but the services were provided at different addresses, each service must be submitted with line level information. This will provide a ZIP code to price each service on the claim.

B. Paper Claims Submitted on the Form CMS-1500

Note that the following instructions do not apply to services rendered at POS home – 12 or any other places of service contractors consider to be Home. (See §10.1.1.1)

It is acceptable for claims to contain POS home and an additional POS code. No service address for POS home needs to be entered for the service rendered at POS home in this situation as the address will be drawn from the beneficiary file (or wherever else the carrier is currently storing the beneficiary information) and the information on the claim will apply to the other POS.

The provider must submit separate claims for each POS. The specific location where the services were furnished must be entered on the claim. Use the ZIP code of the address entered in Item 32 to price the claim. If multiple POS codes are submitted on the same claim, treat assigned claims as unprocessable and follow the instructions in §§80.3.1. Carriers must continue to follow their current procedures for handling unprocessable unassigned claims.

Use the following messages:

> Remittance Advice – Adjustment Reason Code 16 – "Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remark codes whenever appropriate."
>
> Remark Code –M77 – "Missing/incomplete/invalid place of service."
>
> MSN - 9.2 – "This item or service was denied because information required to make payment was missing."

If the contractor receives a fee-for-service claim containing one or more services for which the MPFS payment locality is in another carrier's jurisdiction, handle in accordance with the instructions in §§10.1.9. If you receive a significant volume or experience repeated incidences of misdirected Medicare Physician Fee Schedule claims/services from a particular provider, an educational contact may be warranted. Handle misdirected claims/services for HMO enrollees in accordance with §10.1.1.C and D.

C. Determining the Correct Payment Locality for Services Paid Under the Medicare Physician Fee Schedule (MPFS) and Anesthesia Services When Rendered in a Payment Locality that Crosses ZIP Code Areas

Per the instructions above, Medicare carriers have been directed to determine the payment locality for services paid under the MPFS and anesthesia services by using the ZIP code on the claim of where the service was performed. It has come to the attention of CMS that some ZIP codes fall into more than one payment locality. The CMS ZIP code file uses the convention of the United States Postal Service, which assigns these ZIP codes into dominant counties. In some cases, though the service may actually be rendered in one county, per the ZIP code it is assigned into a different county. This causes a payment issue when each of the counties has a different payment locality and therefore a different payment amount. Please note that as the services on the Purchased Diagnostic Test Abstract file are payable under the MPFS, the 9-digit ZIP code requirements will also apply to those codes.

Effective for dates of service on or after October 1, 2007, CMS shall provide a list of the ZIP codes that cross localities as well as provide quarterly updates when necessary. The CMS ZIP code file shall be revised to two files: one for 5-digit ZIP codes (ZIP5) and one for 9-digit ZIP codes (ZIP9). Providers performing services paid under the MPFS, anesthesia services, or any other services as described above, in those ZIP codes that cross payment localities shall be required to submit the 9-digit ZIP codes on the claim for where the service was rendered. Claims for services payable under the MPFS and anesthesia services that are NOT performed in one of the ZIP code areas that cross localities may continue to be submitted with 5-digit ZIP codes. Claims for services other than those payable under the MPFS or anesthesia services may continue to be submitted with 5-digit ZIP codes.

Beginning in 2009, contractors shall maintain separate ZIP code files for each year which will be updated on a quarterly basis. Claims shall be processed using the correct ZIP code file based on the date of service submitted on the claim.

It should be noted that though some states consist of a single pricing locality, zip codes can overlap states thus necessitating the submission of the 9-digit zip code in order to allow the process to identify the correct pricing locality.

Claims received with a 5-digit ZIP code that is one of the ZIP codes that cross localities and therefore requires a 9-digit ZIP code to be processed shall be treated as unprocessable.

For claims received that require a 9-digit zip code with a 4 digit extension that does not match a 4-digit extension on file, manually verify the 4 digit extension to identify a potential coding error on the claim or a new 4-digit extension established by the U.S. Postal Service (USPS). ZIP code and county information may be found at the USPS Web site at http://www.usps.com/, or other commercially available sources of ZIP code information may be consulted. If this process validates the ZIP code, the claim may be processed. The "Revision to Payment Policies Under the Physician Fee Schedule" that is published annually in the Federal Register, or any other available resource, may be used to determine the appropriate payment locality for the ZIP code with the new 4-digit extension.

If this process does not validate the ZIP code, the claim must be treated as unprocessable.

The following Remittance Advice and Remark Code messages shall be returned for the unprocessable claims:

Adjustment Reason Code 16 – Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remark codes whenever appropriate.

Remark Code MA 130 – Your claim contains incomplete and/or invalid information, and no appeals rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.

Remark Code MA114 – Missing/incomplete/ information on where the services were furnished.

Should a service be performed in a zip code area that does not require the submission of the 9-digit zip code, but the 4-digit extension has been included anyway, carriers shall price the claim using the carrier/locality on the ZIP5 file and ignore the 4-digit extension.

D. ZIP9 Code to Locality Record Layout

Below is the ZIP9 code to locality file layout. Information on the naming conventions, availability, how to download the ZIP5 and ZIP9 files, and the ZIP5 layout can be found in Pub. 100-04, Chapter 15, Section 20.1.6.

ZIP9 Code to Locality Record Layout

(Effective for dates of service on or after October 1, 2007.)

Field Name	Beg. Position	End Position	Length	Comments
State	1	2	2	
ZIP Code	3	7	5	
Carrier	8	12	5	
Pricing Locality	13	14	2	
Rural Indicator	15	15	1	blank=urban, R=rural, B=super rural
Filler	16	20	5	
Plus Four Flag	21	21	1	0 = no +4 extension, 1 = +4 extension
Plus Four	22	25	4	
Filler	26	75	50	
Year/Quarter	76	80	5	YYYYQ

10.1.1.2 - Payment Jurisdiction for Purchased Services

(Rev. 464, Issued: 02-04-05, Effective: 04-01-05, Implementation: 04-04-05)

Diagnostic tests and their interpretations are paid on the MPFS. Therefore, they are subject to the same payment rules as all other services paid on the MPFS. Additional explanation is provided here due to general confusion concerning these services when they are purchased and then billed, rather than rendered and billed by the billing entity. As for any other services, suppliers must also meet current enrollment criteria as stated in chapter 10 of the Program Integrity Manual in order to be able to enroll and bill for purchased tests and interpretations. That these services are purchased does not negate the need for appropriate enrollment procedures with the carrier that has jurisdiction over the geographic area where the services were rendered. Carriers must follow the instructions in §10.1.9 if they receive claims for services outside their jurisdiction.

Effective for claim processed on or after April 1, 2004, in order to allow the carrier to determine jurisdiction, price correctly, and apply the purchase price limitations, global billing will not be accepted for purchased services on electronic or paper claims. Claims received with global billings in this situation will be treated as unprocessable per §80.3.

A. Payment Jurisdiction for Suppliers of Diagnostic Tests for Purchased Interpretations

Per §30.2.9.1, suppliers (including laboratories, physicians, and independent diagnostic testing facilities [IDTFs]) may receive payment for purchased interpretations. Effective for claims with dates of service on or after January 25, 2005, laboratories, physicians, and IDTFs must submit all claims for purchased interpretations to their local carrier. Carriers must accept and process claims for purchased interpretations when billed by suppliers enrolled in the carrier's jurisdiction, regardless of the location where the service was furnished. Carriers should allow claims submitted by an IDTF for purchased interpretations if the IDTF has previously enrolled to bill for purchased diagnostic test components it performs.

B. Payment Jurisdiction for Suppliers for Purchased Diagnostic Tests

Per §30.2.9, suppliers (including laboratories, physicians, and IDTFs) may receive payment for purchased diagnostic tests. Effective for claims with dates of service on or after January 25, 2005, suppliers (including laboratories, physicians, and independent diagnostic testing facilities [IDTFs]) must submit all claims for purchased diagnostic tests to their local carrier. Carriers must accept and process claims for purchased diagnostic tests when billed by suppliers enrolled in the carrier's jurisdiction, regardless of the location where the service was furnished.

10.1.1.3 - Payment Jurisdiction for Reassigned Services

(Rev. 169, 05-07-04)

Though a supplier or provider may reassign payment for his services to another entity; that does not negate the necessity of billing the correct carrier for those services when they are services paid under the MPFS. The entity that will be billing for the services must still bill the carrier that has jurisdiction over the geographic area where the services were rendered. suppliers and providers must also meet current enrollment criteria as stated in chapter 10 of the Program Integrity Manual in order to be able to enroll and bill for reassigned services.

10.1.3 - Exceptions to Jurisdictional Payment

(Rev. 1, 10-01-03)

B3-3100.6, R1813B3

Exceptions to billing the area carrier are:

- A claim for covered services performed in the United States by a legally authorized Canadian or Mexican physician is within the jurisdiction of the carrier servicing the location where the services were rendered.
- Because coverage of Part B services furnished in Canada or Mexico is contingent upon coverage of related inpatient hospital services, carriers designated to process foreign claims identified in §10.1.4.2 will receive such claims from the FI servicing the foreign hospital only after the FI has determined that the Part A services are covered. (If the request is for payment of medical services performed outside the United States by a physician or supplier whose office is located in the United States, the carrier servicing the physician's or supplier's office has jurisdiction. This carrier issues the denial determination and handles any resultant appeal.)
- If a claim by an individual who resides outside the United States involves both medical services performed within the United States and medical services performed outside the United States the carrier will process both segments of the claim.

10.1.4 - Services Received by Medicare Beneficiaries Outside the United States

(Rev. 1677; Issued: 02-13-09; Effective/Implementation Date: 03-13-09)

Items and services furnished outside the United States are excluded from coverage except for the following services, and certain services rendered on board a ship:

- Emergency inpatient hospital services where the emergency occurred:
    - While the beneficiary was physically present in the United States; or
    - In Canada while the beneficiary was traveling without reasonable delay and by the most direct route between Alaska and another State.

See chapter 3, Inpatient Hospital Billing, Section 110 for a description of claims processing procedures.

- Emergency or nonemergency inpatient hospital services furnished by a hospital located outside the United States, if the hospital was closer to, or substantially more accessible from, the beneficiary's United States residence than the nearest participating United States hospital that was adequately equipped to deal with, and available to provide treatment for the illness or injury (see Chapter 3, Inpatient Hospital Billing, Section 110 for a description of claims processing procedures);

- Physician and ambulance services furnished in connection with a covered foreign hospitalization. Program payment may not be made for any other Part B medical and other health services, including outpatient services furnished outside the United States (see Chapter 1, General Billing Requirements, Section 10.1.4.1, for a description of claims processing procedures);

- Services rendered on board a ship in a United States port, or within 6 hours of when the ship arrived at, or departed from, a United States port, are considered to have been furnished in United States territorial waters. Services not furnished in a United States port, or within 6 hours of when the ship arrived at, or departed from, a United States port, are considered to have been furnished outside United States territorial waters, even if the ship is of United States registry (see Chapter 1, General Billing Requirements, Section 10.1.4.7, for a description of claims processing procedures).

The term "United States" means the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, American Samoa and, for purposes of services rendered on a ship, includes the territorial waters adjoining the land areas of the United States.

A hospital that is not physically situated in one of the above jurisdictions is considered to be outside the United States, even if it is owned or operated by the United States Government.

Payment may not be made for any item provided or delivered to the beneficiary outside the United States, even though the beneficiary may have contracted to purchase the item while he or she was within the United States or purchased the item from an American firm.

Under the Railroad Retirement Act, payment is made to qualified Railroad Retirement beneficiaries (QRRBs) by the RRB for covered hospital services furnished in Canadian hospitals as well as in the U.S. Physician and ambulance services are not covered by the Railroad Retirement Act; however, under an agreement between CMS and RRB, if the QRRB claims payment for Part B services in connection with Canadian hospitalization, RRB processes the Part B claim. In such cases the RRB determines:

- Whether the requirements are met for the inpatient services; and

- Whether the physician and/or ambulance services were furnished in connection with the services.

Services for an individual who has elected religious nonmedical health care status may be covered if the above requirements are met but this revokes the religious nonmedical health care institution election.

10.1.4.1 - Physician and Ambulance Services Furnished in Connection With Covered Foreign Inpatient Hospital Services

(Rev. 1677; Issued: 02-13-09; Effective/Implementation Date: 03-13-09)

Payment is made for necessary physician and ambulance services that meet the other coverage requirements of the Medicare program, and are furnished in connection with a covered foreign hospitalization.

A. Coverage of Physician and Ambulance Services Furnished Outside the U.S.

Where inpatient services in a foreign hospital are covered, payment may also be made for:

- Physicians' services furnished to the beneficiary while he/she is an inpatient,

- Physicians' services furnished to the beneficiary outside the hospital on the day of his/her admission as an inpatient, provided the services were for the same condition for which the beneficiary was hospitalized (including the services of a physician who furnishes emergency services in Canadian waters on the day the patient is admitted to a Canadian hospital for a covered emergency stay) and,

- Ambulance services, where necessary, for the trip to the hospital in conjunction with the beneficiary's admission as an inpatient. Return trips from a foreign hospital are not covered.

In cases involving foreign ambulance services, the general requirements in chapter 15 are also applicable, subject to the following special rules:

- If the foreign hospitalization was determined to be covered on the basis of emergency services, the medical necessity requirements outlined in chapter 15 are considered met.

- The definition of "physician," for purposes of coverage of services furnished outside the U.S., is expanded to include a foreign practitioner, provided the practitioner is legally licensed to practice in the country in which the services are furnished.

- Only the enrollee can file for Part B benefits; the assignment method may not be used.

  - Where the enrollee is deceased, the rules for settling Part B underpayments are applicable. Payment is made to the foreign physician or foreign ambulance company on an unpaid bill provided the physician or ambulance company accepts the payment as the full charge for the service, or payment can be made to a person who has agreed to assume legal liability to pay the physician or supplier. Where the bill is paid, payment may be made in accordance with Medicare regulations. The regular deductible and coinsurance requirements apply to physicians' and ambulance services furnished outside the U.S.

10.1.4.2 - Carriers Designated to Process Foreign Claims

(Rev. 1, 10-01-03)

B3-2312.3

The following carriers are designated to process claims for physicians' and ambulance services furnished in connection with a covered hospital stay in Canada and Mexico.

Canadian Claims

Provinces:	**Carriers:**
New Brunswick	National Heritage Insurance Co.
Newfoundland	Medicare Part B
	75 William Sgt. Terry Drive

Nova Scotia Quebec Prince Edward Island	Hingham, MA 02044-9194
Ontario	Wisconsin Physician Services Medicare Part B P.O. Box 5555 Marion, IL 62959
Saskatchewan Alberta Manitoba	Blue Cross Blue Shield of Montana 404 Fuller Avenue Helena, MT 59601
British Columbia Vancouver Yukon Territories	Noridian Mutual Insurance Co. Medicare Part B P.O. Box 6028 Fargo, ND 58108-6028

Mexican Claims

Areas	**FIs:**
Western Mexico (Sonora and the Bajas)	National Heritage Insurance Co. Medicare Part B P.O. Box 27852 Chico, CA 95927-2852
Eastern Mexico (Chihuahua, Coahuila, Nuevo Leon, Tamaulipas, etc.)	Trailblazer Health Enterprises Medicare Part B P.O. Box 660156 Dallas, TX 75265

The above carriers are designated to determine whether the requirements in §10.1.4.1 are met for claims for inpatient services based upon the geographic location of the foreign hospitals furnishing the services.

If a carrier is not designated to process these claims, it must send them to the appropriate carrier for proper handling and routing only if there is evidence the Part B services were furnished in connection with covered inpatient hospital services in Canada or Mexico. If there is no evidence, the carrier must send a front-end rejection notice in accordance with §10.1.4.3.

10.1.4.3 - Source of Part B Claims

(Rev. 654; Issued: 08-19-05; Effective and Implementation Dates: 11-17-05)

Because coverage of Part B services furnished by a hospital located outside the United States is contingent upon coverage of related inpatient hospital services, carriers designated in §10.1.4.2 will receive such claims from the FI servicing the foreign hospital only after the FI has determined that the Part A services are covered. (However, if the claimant is a qualified railroad retirement beneficiary, see §10.1.4.6 for special procedures.)

NOTE: If a designated carrier in §10.1.4.2 receives a claim for Part B services (that were furnished outside the United States) from any source other than an FI and there is an indication the services were furnished in connection with covered inpatient services, carriers send the claim to the appropriate FI. If the claim does not show that the beneficiary was hospitalized, carriers send the beneficiary a front-end rejection notice. In filling out the Notification of Medicare Determination, carriers check "other" and include the following explanation: "Foreign physician or ambulance services are not covered unless they were furnished in connection with a covered inpatient stay."

The FI controls the claim and holds it pending a determination on the related Part A claim.

The following FIs are responsible for processing foreign claims:

Canadian Claims

Provinces:	**FIs:**
New Brunswick Newfoundland Nova Scotia Quebec Prince Edward Island	Associated Hospital Services of Maine 2 Gannett Drive Portland, Maine 04106-6911
Ontario	United Government Services, LLC P.O. Box 9150 Oxnard, CA 93031
Saskatchewan Alberta Manitoba	Blue Cross of Montana 3360 10th Avenue, South P.O. Box 5017 Great Falls, Montana 59403
British Columbia Vancouver Yukon Territories	Noridian Administrative Services Medicare Operations Center 901 40th St S Suite 1 Fargo, ND 58103

Mexican Claims

Areas	Carriers:
Western Mexico (Sonora and the Bajas)	Blue Cross of California 21555 Oxnard St. Woodland Hills, CA 91367
Eastern Mexico (Chihuahua, Coahuila, Nuevo Leon, Tamaulipas, etc.)	Trail Blazer Health Enterprises, LLC, 8330 LBJ Freeway, Executive Center III, Dallas, Texas 75243

Prior to submitting the claim to the carrier, the FI determines whether the requirements in §10.1.4.1.A and B are met. If these requirements are not met, the FI denies the Part A claim and related Part B claim and notifies the enrollee. Where the FI determines that the requirements in §10.1.4.1.A or B are met, the Part A FI determines whether other applicable Part A coverage requirements are met. If the FI disallows the Part A claim, it denies the related Part B claim and notifies the enrollee. If the FI approves the Part A claim, it sends the Part B claim to the appropriate carrier for consideration of whether the other requirements for Part B coverage are met, and for further processing. However, carriers will not be involved in the processing of foreign claims if, for any reason, the related Part A claim is denied. Claims for services provided in countries other than Canada or Mexico should be sent to the carrier who is responsible for the state or territory where the emergency arose. In other words, the foreign claim would be processed similarly to how claims are processed in the state or territory where the emergency arose.

10.1.4.4 - Medicare Approved Charges for Services Rendered in Canada or Mexico

(Rev. 1, 10-01-03)

B3-2312.5

For Canadian services, the Medicare approved charge will be the lower of:

1. The allowed amount for the same service in the U.S. locality closest to where the service was furnished (as determined by the designated carrier), or
2. The Canadian Provincial fee.

Therefore, the designated carrier must obtain the most recent schedule of fees published by the appropriate Canadian Province. Most of the designated carriers deal with only one Provincial schedule.

For Mexican services, the maximum charge is the Medicare allowed amount for the same service in the locality closest to where the service was furnished (as determined by the designated carrier).

10.1.4.5 - Appeals of Denied Charges for Physicians and Ambulance Services in Connection With Foreign Hospitalization

(Rev. 654; Issued: 08-19-05; Effective and Implementation Dates: 11-17-05)

Where a request for review of an initial determination is received, the office that made the initial determination will conduct the review. If the request deals with an initial determination made by the Regional Office (RO), the RO will conduct the review and will notify the enrollee of the decision; if the request relates to a carrier determination, the carrier will conduct the review determination and notify the enrollee.

All requests for a hearing on claims for physician/ambulance services furnished in foreign countries fall within the jurisdiction of a hearing officer of the appropriate carrier in §10.1.4.2 regardless of who made the review determination. However, a hearing request on an RO review determination (e.g., whether the emergency or accessibility requirements are met) will normally be in connection with the Part A claim and will be considered and processed as such. If, however, the enrollee already had a Part A hearing on the RO part of the decision and then requests a hearing on the same issue for the Part B claim, the RO should forward all pertinent information regarding the initial and review determinations and the hearing to the carrier as soon as it is aware of the Part B hearing request.

10.1.4.6 - Claims for Services Furnished in Canada and Mexico to Qualified Railroad Retirement Beneficiaries

(Rev. 1, 10-01-03)

B3-2312.7

All claims for hospital and/or related physician or ambulance services furnished in Canada to qualified railroad retirement beneficiaries (QRRB's) are forwarded first to the Railroad Retirement Board (RRB).

Under the Railroad Retirement Act, payment may be made by the RRB on behalf of QRRB's for covered hospital services furnished in Canada.

When physician or ambulance services are furnished a QRRB in connection with covered hospitalization in Canada, the RRB examines the services to see if the requirements in §10.1.4.1.A or B are met. If these requirements are not met, the RRB will deny the claim and notify the beneficiary. Where the RRB determines that the requirements in §10.1.4.1.A or B are met, the RRB forwards the claim to Palmetto GBA for consideration of whether the other requirements for Part B coverage are met, and further processing.

The RRB does not pay for health care services furnished in Mexico. All claims for inpatient hospital services and/or related physician or ambulance services furnished in Mexico to QRRB's should be forwarded directly to the Regional Office (RO). If the RO determines that the requirements in §10.1.4.1.A or B are not met, the RO will deny the claim and send notice to the beneficiary. If the requirements in §10.1.4.1.A or B are met, the RO will hold any potentially allowable Part B claim until an FI determination regarding the coverage of Part A services has been made. When the information regarding Part A coverage is available, the RO will send the Part B claim, together with pertinent information regarding the Part A determination, to Palmetto Government Benefits for consideration of whether the other requirements for Part B coverage are met, and further processing.

10.1.4.7 - Shipboard Services Billed to the Carrier

(Rev. 1677; Issued: 02-13-09; Effective/Implementation Date: 03-13-09)

The following services furnished aboard a vessel are covered:

- Emergency and nonemergency services furnished by a physician or supplier aboard a vessel are covered when the ship is within the territorial waters of the United States. If the emergency or nonemergency services were furnished within the territorial waters of the United States and the physician or supplier refuses to submit the claim on the beneficiary's behalf (or enroll in Medicare, if applicable), then the contractor must follow the compliance monitoring instructions outlined at Pub. 100-04, chapter 1, section 70.8.8.6B because these claims are not processed as foreign claims.

- Emergency services furnished by a physician or supplier aboard a vessel are covered when the services are rendered while the ship is within the territorial waters of Canada (while the individual was traveling, by the most direct route and without unreasonable delay between Alaska and another State) and the emergency services are furnished in connection with a covered foreign hospitalization in Canada. The compliance monitoring instructions outlined at Pub. 100-04, chapter 1, section 70.8.8.6B do not apply to these claims because they are processed as foreign claims.

See section 10.1.4 for the definitions of "territorial waters" and "United States."

Jurisdiction of claims for shipboard services is determined by the following rules:

A. Ship Physician's Office is in the United States.

The carrier serving the physician's office in the United States always has jurisdiction. The physician's office can include the home office of the shipping line in the United States if the physician customarily bills from that office.

B. Ship Physician's Office is Outside of the United States.

When the physician's office is outside of the United States, jurisdiction is determined as follows:

- The carrier serving the final port of debarkation has jurisdiction if the beneficiary's trip terminates in the United States;

- The carrier serving the port of embarkation has jurisdiction if the beneficiary's trip originates in the United States.

The carrier having jurisdiction for a claim for services performed aboard ship has jurisdiction for the entire claim regardless of whether the beneficiary's trip included territorial waters of more than one State or other United States entity or whether or not only portions of the claim may be paid.

MSN message:

16.240-
Medicare may pay for services that you get while on board a ship within the territorial waters of the United States. In rare cases, Medicare may pay for inpatient hospital, doctor, or ambulance services you get if you are traveling through the territorial waters of Canada without

unreasonable delay by the most direct route between Alaska and another state when a medical emergency occurs and the Canadian hospital is closer than the nearest U.S. hospital that can treat the emergency. Medicare won't pay for this service since you didn't meet these requirements.

16.240-
Medicare puede pagar por los servicios que usted recibe, mientras esta a bordo de un barco, en aguas territoriales cercanas a los Estados Unidos. En muy pocos casos, Medicare podría pagar por los servicios de internación en el hospital, el médico o la ambulancia si está viajando a través de Canadá sin causar demoras innecesarias por la ruta más directa entre Alaska y otro estado cuando una emergencia médica ocurre y el hospital de Canadá está más cerca que un hospital de Estados Unidos para tratar la situación de emergencia. Medicare no pagará por estos servicios, ya que no cumplió con este requisito.

10.1.4.8 – Payment Denial for Medicare Services furnished to Alien Beneficiaries Who are Not Lawfully Present in the United States

(Rev. 296, Issued: 09-03-04, Implementation: 09-03-04)

Medicare payment may not be made for items and services furnished to an alien beneficiary who was not lawfully present in the United States on the date of service.

The CWF must establish an auxiliary file based on enrollment data contained in the Enrollment Data Base maintained by the Social Security Administration in order to appropriately edit the claims specifically associated with alien beneficiaries. The auxiliary file will be the basis for an edit that rejects claims for a beneficiary that was not lawfully present in the U.S. on the date of service. Carriers and DMERCs must deny claims for items and services, rejected by CWF on the basis that the beneficiary was not lawfully present in the U.S. on the date of service. Carriers and DMERCs must refer to the CWF documentation on this subject for the error code MSN Message 5.7, assigned to this editing.

Upon receipt of an error code MSN Message 5.7, carriers, DMERCs, intermediaries, and RHHIs must deny the claim and use reason code 30, "Payment adjusted because the patient has not met the required eligibility, spend down, waiting or residency requirements." When CWF rejects a claim, carriers and DMERCs must use MSN message 5.7, "Medicare payment may not be made for the item or service because, on the date of service, you were not lawfully present in the United States." 5.7, Medicare no puede pagar por este artículo o servicio porque, en la fecha en que lo recibió, usted no estaba legalmente en los Estados Unidos.

A party to a claim denied in whole or in part under this policy may appeal the initial determination on the basis that the beneficiary was lawfully present in the United States on the date of service. All contractors must inform affected provider communities by posting relevant portions of this instruction on their Web sites within 2 weeks of the issuance date on this instruction. In addition, this same information must be published in your next regularly scheduled bulletin. If you have a listserv that targets the affected provider communities, you must use it to notify subscribers that information "Medicare Services for Alien Beneficiaries Lawfully present the United States" is available on your Web site.

NOTE: Section 401 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), codified at 8 U.S.C. §1611, prohibits aliens who are not "qualified aliens" from receiving Federal public benefits including Medicare.

However, Section 5561 of the Balanced Budget Act of 1997 (BBA) amended Section 401 of the PRWORA to create a Medicare exemption to the prohibition on eligibility for non-qualified alien beneficiaries, who are lawfully present in the United States and who meet certain other conditions. Specifically, payment may be made for services furnished to an alien who is lawfully present in the United States (and provided that with respect to benefits payable under Part A of Title XVIII of the Social Security Act [42 U.S.C. 1395c et seq.], who was authorized to be employed with respect to any wages attributable to employment which are counted for purposes of eligibility for Medicare benefits). The definition for "lawfully present in the United States" is found at 8 CFR 103.12.

10.1.5 - Domestic Claims Processing Jurisdictions

(Rev. 1, 10-01-03)

B3-3102, B3-3116

10.1.5.1 - Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, Supplies, Parental and Enteral Nutrition (PEN)

(Rev. 1, 10-01-03)

B3-3116, B-3102

Claims for DMEPOS submitted by suppliers for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) are handled by DME Regional Carriers (DMERCs).

To determine which services are processed by DMERCs vs. local carriers, CMS maintains and updates a table of services by HCPCS code that indicates who to bill for which services. The CMS updates this list by a special One-Time Special Notification as needed. In general, claims for DMEPOS, other than implanted durable medical equipment and implanted prosthetic devices, are processed by the appropriate DMERC. The appropriate local carrier processes claims for implanted durable medical equipment and implanted prosthetic devices, as well as DMEPOS items incident to a physician's service.

Note that **surgical procedures** for implantable DME or for prosthetic devices, performed in an inpatient or outpatient hospital setting include the cost of the device in the Diagnosis Related Group (DRG) or Ambulatory Payment Classification (APC) rate. However, there are some implantable devices that are eligible for separate pass through under Outpatient Prospective Payment System (OPPS). DMERCs do not process claims for DMEPOS items that are subject to consolidated billing or bundled payment under Prospective Payment System (PPS) or in a DRG.

Claims from parenteral and enteral nutrition (PEN) suppliers are processed by the DMERC.

Method II ESRD claims are also processed by the DMERC.

The claims processing jurisdiction among DMERCs carriers is determined by the beneficiary's permanent address. A beneficiary's permanent address is determined by where the beneficiary resides for more than six months of a year. See the CMS Web site at http://www.cms.hhs.gov/contacts/incardir.asp for a list of State jurisdictions by DMERC.

10.1.5.2 - Supplier of Portable X-Ray, EKG, or Similar Portable Services

(Rev. 1, 10-01-03)

If a supplier operates mobile units in geographic areas served by more than one carrier, the carrier serving the area where the service was performed must process the claims.

10.1.5.3 - Ambulance Services Submitted to Carriers

(Rev. 1, 10-01-03)

Jurisdiction of the claim is based on whether only one ambulance vehicle or multiple vehicles were used.

A. One Ambulance Vehicle Used

If only one vehicle is used to transport the patient from the point of initial pickup to the final destination, jurisdiction is with the carrier serving the point of origin, i.e., home station of the vehicle. This carrier has qualification information on the ambulance supplier and in most cases all other pertinent details necessary to adjudicate a claim.

EXAMPLE: A patient is picked up at the Johns Hopkins Hospital in Baltimore, Maryland and transported to his home in West Virginia by an ambulance dispatched from the area of the patient's home. The carrier serving the point of origin of the ambulance, Nationwide Mutual Insurance Company, Part B carrier for the State of West Virginia, has jurisdiction of any claim filed. In this case Nationwide should have all the data necessary to make proper payment, i.e., certification of the ambulance company, price information and data pertaining to the nearest appropriate company, price information and data pertaining to the nearest appropriate facility. Had an ambulance whose home station was in Baltimore been used, the carrier servicing Baltimore, Maryland would have had jurisdiction. The Baltimore carrier would then have had to obtain data concerning the nearest appropriate facility to the patient's home from Nationwide

B. More Than One Vehicle Used

If more than one vehicle is used in transporting the patient to their destination, jurisdiction of the claim lies with:

- The carrier serving the home base of the ambulance taking the patient on the **first leg of the trip**, on a trip **to** a distant institution more remote than the nearest appropriate facility; or
- The carrier serving the home base of the ambulance taking the patient on the **final leg** of the trip home, on a trip **from** an institution more remote than the nearest appropriate facility.
- If there is **no** claim for the final leg of the trip, the carrier serving the patient's home area handles any resulting claims or disallowance actions.

EXAMPLE: A patient is transported by ambulance from a hospital in Miami Beach, Florida to Miami International Airport and from there by air ambulance to LaGuardia Airport in Queens, New York City. At the airport he is picked up by an ambulance (based in Yonkers, New York) and taken to his home in Yonkers, New York. The carrier that handles the adjudication is the carrier whose area of responsibility includes Yonkers, New York, since partial reimbursement is based upon the nearest appropriate facility to his residence when he is being returned home from a distant institution.

In rules A and B above, the principle followed is that the carrier having the information to determine the "nearest appropriate facility" is the one to adjudicate the claim. In any event, before **any** partial reimbursement can be made, the carriers as designated in rules A and B, must

have all the information concerning the patient's transportation, **from initial pickup to final destination**.

10.1.5.4 - Independent Laboratories

(Rev. 1, 10-01-03)

Jurisdiction of claims for laboratory services furnished by an independent laboratory normally lies with the carrier serving the area in which the laboratory test is performed. However, there are some situations where a regional or national lab chain jurisdiction is with a single carrier.

10.1.5.4.1 - Cases Involving Referral Laboratory Services

(Rev. 1, 10-01-03)

If the specimen is drawn or received by an independent laboratory approved under the Medicare program that performs a covered test, but the lab refers the specimen to another laboratory in a different carrier jurisdiction for additional tests, the carrier servicing the referring laboratory retains jurisdiction for services performed by the other laboratory.

Examples of Independent Laboratory Jurisdiction

EXAMPLE 1:

An independent laboratory located in Oregon performs laboratory services for physicians whose offices are located in several neighboring States. A physician from Nevada sends specimens to the Oregon laboratory. If the laboratory sends the results to the physician and accepts assignment, the carrier in Oregon has jurisdiction.

EXAMPLE 2:

American Laboratories, Inc., is an independent laboratory company with branch laboratories located in Philadelphia, Pennsylvania, and Wilmington, Delaware, as well as regional laboratories located in Millville, New Jersey, and Boston, Massachusetts.

The Philadelphia laboratory receives a blood sample from a patient whose physician ordered a complete blood count, an SMAC T-4, and a B12 and folate. The Philadelphia lab performs the complete blood count, but the SMAC T-4 is performed at the Millville lab, while the B12 and folate is performed at the Boston Lab. The Pennsylvania carrier retains jurisdiction for processing the claims **if they have certification information and the appropriate fee schedule allowance in house**. Otherwise, the local carrier servicing Boston and/or Millville has jurisdiction for processing their claims.

The Wilmington laboratory draws a blood specimen from a patient whose physician has ordered a blood culture. The Wilmington lab then sends the specimen to the Boston laboratory, which performs the required test. American Laboratories accepts an assignment for the service.

If the Delaware carrier has the capability of comparing the Wilmington lab's charge for the blood culture against the appropriate reasonable charge screens for the Boston lab, the Delaware carrier will retain jurisdiction for processing the claim. If the Delaware carrier does not have this capability, the claim should be transferred to the Massachusetts carrier for processing.

10.1.6 - Railroad Retirement Beneficiary Carrier

(Rev. 142, 04-16-04)

B3-3103

Carrier jurisdiction claims for individuals who are QRRBs, including those who are entitled to both social security and railroad retirement benefits, are handled by the Palmetto Government Benefits Administrators (GBA) LLC, a subsidiary of Blue Cross and Blue Shield of South Carolina, with the following exceptions:

- The services are furnished by a M+C organization which deals directly with CMS on a cost basis;
- The QRRB is enrolled under a buy-in agreement involving a State agency that has entered into an agreement to act as a carrier with respect to such individuals; or;
- The medical services were provided outside the United States, in which case the RRB handles the claim. (See §10.1.4.6 for handling claims for services in Mexico.)

If a claim involves medical services provided both within and outside the United States, Palmetto GBA processes the claim for the medical services provided within the United States. If the claimant raises a question as to why the medical services provided outside the United States were not paid, Palmetto GBA directs the claimant to contact the RRB and forwards the claims to them at:

Railroad Retirement Board
Division of Disability and Health Insurance
844 Rush St.
Chicago, IL 60611

10.1.7 - Welfare Carriers

(Rev. 1, 10-01-03)

B3-3104, B3-3060 for buy-in definition

Section 1843(f) of Title XVIII permits a State agency that administers a plan under Titles I, XVI, or XIX to become the carrier for individuals enrolled in the State's Buy In agreement. Currently there are no State agencies that are serving as carriers.

10.1.9 - Disposition of Misdirected Claims to the Carrier

(Rev. 593, Issued: 06-24-05, Effective: N/A, Implementation: N/A)

This section applies to misdirected carrier claims that are payable by local carriers and have been sent to the wrong carrier or are payable by the Railroad Retirement Board (RRB), the United Mine Workers of America (UMWA), or the Indian Health Service (IHS) but have been mistakenly sent to the local carrier. This section also applies to claims that are payable by Durable Medical Equipment Regional Carriers (DMERC) and have been sent to the wrong DMERC. Current processes per the DMERC statement of work should be followed for misdirected claims that have been mistakenly sent to the wrong DMERC. This section does not apply to misdirected claims that are payable by a DMERC, but have mistakenly been sent to the local carrier or vice versa. DMERCs and carriers should continue with current claims processing procedures for these claims.

10.1.9.1 – A Local Carrier Receives a Claim with Some or All Services that are in Another Local Carrier's Payment Jurisdiction

(Rev. 142, 04-16-04)

When you receive a request for Medicare payment for services furnished outside of your payment jurisdiction, return assigned services as unprocessable, and deny unassigned services. Pay services correctly submitted to you.

Use the following messages:

Remittance Advice (RA) - Claim adjustment reason code 109 – Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.

Remark code N104 - This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS Web site at www.cms.hhs.gov.

Medicare Summary Notice (MSN) - 11.7 – This claim/service is not payable under our claims jurisdiction area. We have notified your provider that they must forward the claim/service to the correct carrier for processing.

Spanish - Esta reclamación/servicio no se paga bajo nuestra juridicción de reclamaciones. Le hemos notificado a su proveedor que debe enviar la reclamación/servicio a la agencia de seguros de Medicare Parte B apropiada para ser procesada.

10.1.9.2 - A Local Carrier Receives a Claim for an RRB Beneficiary

(Rev. 142, 04-16-04)

When you receive a request for Medicare payment from a provider for RRB beneficiaries, return as unprocessable assigned services and deny unassigned services. Pay services correctly submitted to you.

Use the following messages:

RA - Claim adjustment reason code 109 – Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.

Remark code N105 - This is a misdirected claim/service for a RRB beneficiary. Submit paper claims to the RRB carrier: Palmetto GBA, P.O. Box 10066, Augusta, GA 30999. Call 866-749-4301 for RRB EDI information for electronic claims processing.

MSN - 11.9 – This claim/service is not payable under our claims jurisdiction. We have notified your provider to send your claim for these services to the Railroad Retirement Board Medicare carrier.

Spanish - Esta reclamación/servicio no se paga bajo nuestra juridicción de reclamaciones. Le hemos notificado a su proveedor que debe enviar la reclamación por estos servicios a la Junta de Retiro Ferroviario (RRB, por sus siglas en inglés), agencia de seguros de Medicare Parte B.

NOTE: The CMS requests that when RRB receives a claim that is not for an RRB beneficiary that they return the claim to the sender and notify them that the claim must be submitted to the local carrier or DMERC for processing.

10.1.9.3 - A Local Carrier Receives a Claim for a UMWA Beneficiary

(Rev. 593, Issued: 06-24-05, Effective: N/A, Implementation: N/A)

When the local carrier receives a request for Medicare payment that should be processed by the UMWA, return as unprocessable assigned services and deny unassigned services.

Use the following messages:

RA - Claim adjustment reason code 109 - Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.

Remark code N127 – This is a misdirected claim/service for a United Mine Workers of America (UMWA) beneficiary. Please submit claims to them.

MSN - 11.11 – This claim/service is not payable under our claims jurisdiction. We have notified your provider to send your claim for these services to the United Mine Workers of America for processing.

11.11 - Esta reclamación/servicio no se paga bajo nuestra jurisdicción de reclamaciones. Le hemos notificado a su proveedor que debe enviar la reclamación por estos servicios a la Unión de Trabajadores Mineros de América.

10.1.9.4 - Medicare Carrier or RRB-Named Carrier to Welfare Carrier

(Rev. 1, 10-01-03)

When a Medicare carrier or RRB-named carrier receives a query reply from CMS that includes a disposition code 46 and a welfare administration carrier number, it transfers the claim to the welfare carrier and notifies the beneficiary. Any pertinent information received or developed is transferred with the claim.

This occurs only if there is a State welfare carrier and the individual is identified in the beneficiary master record as a State buy-in enrollee for that State.

10.1.9.5 - Protests Concerning Transfer of Requests for Payment to Carrier

(Rev. 72, 01-23-04)

If Palmetto GBA receives a protest concerning the transfer of a request for Medicare payment to the carrier, the protest, including pertinent name and claim number(s) information, is forwarded to:

Railroad Retirement Board
Medicare Section
844 Rush Street
Chicago, IL 60611

10.1.9.6 - Transfer of Claims Material Between Carrier and Intermediary (FI)

(Rev. 1, 10-01-03)

B3-3110.1, B3-3110.2

If a beneficiary erroneously submits a Form CMS-1490 (beneficiary-filed claim form) to a carrier with an itemized bill for services that must be paid by the FI, the carrier forwards such claims to the FI for the necessary action. The FI will inform the provider to submit a claim once the information is received from the carrier.

If the claim covers a combination of services both within and outside the carrier's jurisdiction the carrier should retain the Form CMS-1490 and any claims material needed for processing and forward a photocopy of the Form CMS-1490 and other claims materials to the other involved carrier(s) or FI(s). The carrier should notify the beneficiary when it transfers the claim.

The patient's signature on the Form CMS-1490 satisfied the signature requirement and protects the filing date for the provider billings. (See §70.1 for time limitations for filing claims).

10.2 - FI Jurisdiction of Requests for Payment

(Rev. 1, 10-01-03)

The FIs have jurisdiction for the following:

- All Part A services (hospital, SNF, HHA, and hospice);
- Most Part B services from providers that furnish Part A services; and
- Part B facility services from CORFs, Renal; Dialysis Facilities, Rural Health Clinics, Religious Nonmedical Institutions, Outpatient Physical Therapy Centers, Federally Qualified Health Centers, and Community Mental Health Centers. For example, rural health clinics may bill physician services to carriers under applicable physician provider numbers on carrier-compliant claim formats. Also, some DMEPOS may be billed by home health agencies on claims sent to RHHIs, and some physician, lab and ambulance services may be billed by some types of providers submitting claims to FIs.

Within this general framework, specific jurisdiction among FIs is determined by which FI has received the official tie-in notice from the CMS RO. See §20 for procedures for provider nomination of its FI. Once an FI is assigned, that FI has jurisdiction for all services furnished by the provider or supplier, except those service outside the provider/suppliers scope of service. See the Medicare Claims Processing Manual chapters relating to the service for a description of who may bill the individual service, e.g. lab (Chapter 17) or DME (Chapter 20).

The RHHIs have jurisdiction for HHA and Hospice claims.

There is a national single FI for FQHCs. United Government Systems processes all claims from independent FQHCs.

Regional RHC FIs have jurisdiction for claims from freestanding RHCs. See http://www.cms.hhs.gov/contacts/incardir.asp for a listing of RHC regional FIs. The host provider's area FI has jurisdiction for provider based RHCs and FQHCs.

In addition some provider chains may elect a single FI for all providers in the chain.

A complete list of FIs and carriers and their service areas may be viewed at: http://www.cms.hhs.gov/contacts/incardir.asp.

Note that some providers and supplier under FI claims jurisdiction may also provide covered services outside the scope of the facility service, and may bill these services to the carrier.

Claims sent to the incorrect FI are returned to the provider with an instruction to bill the correct FI.

10.2.1 - FI Payment for Emergency and Foreign Hospital Services

(Rev. 1, 10-01-03)

A. Beneficiary Services Outside United States - Emergency Hospital Admissions

See chapter 3, for detailed information concerning beneficiary services outside the United States. Generally, payment is made for emergency inpatient hospital services in qualified Canadian or Mexican hospitals in the following circumstances:

- A Medicare beneficiary is in the United States when an emergency occurs, and a Canadian or Mexican hospital is closer to, or more accessible from, the site of the

emergency than the nearest adequately equipped United States hospital that can provide emergency services, or

- The emergency occurred in Canada while the beneficiary is traveling between Alaska and another State without unreasonable delay and by the most direct route, and a Canadian hospital is closer to, or more accessible from, the site of the emergency than the nearest United States hospital. For this purpose, an emergency occurring within the Canadian inland waterway between the States of Washington and Alaska is considered to have occurred in Canada.

The term "United States" means the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, Northern Mariana Islands, American Samoa and, for purposes of services furnished on a ship, the territorial waters adjoining the land areas of the U.S.

A hospital that is not physically situated in one of the above jurisdictions is considered to be outside the United States, even if it is owned or operated by the United States Government.

B. Nonemergency Inpatient Services Furnished in Foreign Hospitals

If the beneficiary resides in the United States, and a Canadian or Mexican hospital is closer to, or more accessible from, the beneficiary's home than the nearest adequately equipped United States hospital, Medicare will pay for covered services regardless of whether an emergency exists. Residence means the place in the U.S. where a person has a fixed and permanent home to which he intends to return whenever he is away. At the time such services are furnished, the Canadian or Mexican hospital must be accredited by the JCAH or by a hospital approval program of the country in which it is located having standards essentially equivalent to those of the JCAHO.

10.3 - Payments Under Part B for Services Furnished by Suppliers of Services to Patients of a Provider

(Rev. 1, 10-01-03)

B3-3115

Section 1861(w)(1) of the Act permits a hospital, critical access hospital, skilled nursing facility, home health agency, or hospice to obtain under arrangement, services for which an individual is entitled to under Medicare. Doing so discharges the liability of such individual or any other person to pay for the services. This is required in specified situations where the provider is paid under a PPS system.

Examples of this include:

- While a patient is under a home health plan of care, the HHA must provide all covered and medically reasonable home health services and certain supplies (subject to consolidated billing) either directly or under arrangement.
- Where a patient is a SNF inpatient, the SNF must furnish all services within the scope of the SNH benefit.
- Where a patient is a hospital inpatient, the hospital must furnish certain inpatient services.
- Certain services are considered included in the rural health clinic or federally funded health clinic visit.

In such cases, the supplier must look to the provider for payment and the provider will bill the FI.

In some cases, the hospital, SNF, or HHA may also choose not to arrange for additional services in this and bill for them. In some cases the provider may instead arrange for the supplier to furnish the test and to bill the carrier. The provider may make different arrangements with different suppliers. For example a provider may arrange with a lab supplier for the lab to bill for all outpatient lab services and make arrangements with an x-ray supplier for the provider to bill for all x ray services to inpatients and outpatients.

Similarly the supplier may make different arrangements for services to beneficiaries for whom only Part B benefits are payable, from arrangements for beneficiaries for whom Part A benefits are payable under a PPS system.

The FIs notify carriers of contracts that the hospital, critical access hospital, skilled nursing facility, home health agency, or hospice have reported with their suppliers. The carrier should confirm the supplier's understanding of the arrangements to assure that the supplier does not bill inappropriately.

A description of basic services for each benefit type is in the Medicare Benefit Policy Manual and also in the Medicare Claims Processing Manual chapter specific to the provider.

10.4 – Claims Submitted for Items or Services Furnished to Medicare Beneficiaries in State or Local Custody Under a Penal Authority

(Rev. 883, Issued: 03-10-06, Effective: 04-10-06, Implementation: 06-12-06)

Under Sections 1862(a)(2) and (3) of the Social Security Act, the Medicare program does not pay for services if the beneficiary has no legal obligation to pay for the items or services, or if the items or services are or should be paid for directly or indirectly by a governmental entity. These provisions are implemented by regulations 42 C.F.R.§ 411.4(a) and 411.4 (b), respectively.

Regulations at 42 CFR 411.4(b) state that "Payment may be made for services furnished to individuals or groups of individuals who are in the custody of the police or other penal authorities or in the custody of a government agency under a penal statute only if the following conditions are met: (1) State or local law requires those individuals or groups of individuals to repay the cost of medical services they receive while in custody. (2) The State or local government entity enforces the requirement to pay by billing all such individuals, whether or not covered by Medicare or any other health insurance, and by pursuing the collection of the amounts they owe in the same way and with the same vigor that it pursues the collection of other debts."

Exclusion from Coverage:

In accordance with the foregoing statutory and regulatory provisions, Medicare excludes from coverage items and services furnished to beneficiaries in State or local government custody under a penal statute, unless, it is determined that the State or local government enforces a legal requirement that all prisoners/patients repay the cost of all healthcare items and services rendered while in such custody and also pursues collection efforts against such individuals in the same way, and with the same vigor, as it pursues other debts. CMS presumes that a State or local government that has custody of a Medicare beneficiary under a penal statute has a financial obligation to pay for the cost of healthcare items and services. Therefore, Medicare's policy is to deny payment for items and services furnished to beneficiaries in State or local government custody.

Implementation

CMS has established claim level editing to implement this policy using data received from the Social Security Administration (SSA). Specifically, the data contain the names of the Medicare beneficiaries and time periods when the beneficiary is in such State or local custody. These data will be compared to the data on the incoming claims. CWF will reject claims where the dates from the SSA file and the dates of service on the claim overlap. Any claims rejected by CWF will contain a trailer to the Medicare contractor indicating the date span covered. Contractors will, in turn, deny payment of such claims.

However, providers and suppliers that render services or items to a prisoner or patient in a jurisdiction that meets the conditions of 42 CFR 411.4(b) should indicate this fact with the use of modifier QJ (for carrier or Durable Medical Equipment Regional Carrier (DMERC) processed claims) or condition code 63 (for intermediary processed claims).

Appeals:

A party to a claim denied in whole or in part under this policy may appeal the initial determination on the basis that, on the date of service, (1) the conditions of § 411.4(b) were met, or (2) the beneficiary was not, in fact, in the custody of a State or local government under authority of a penal statute.

Intermediary/RHHI Claims Processing Procedures

Intermediaries must deny claims for items and services rendered to beneficiaries under State or local government custody when CWF rejects the claim. Provide appeal rights as specified above.

Providers that render services or items to a prisoner or patient in a jurisdiction that meets the conditions of 42 CFR 411.4(b) should indicate this fact on the claim. Providers should use the "63" condition code. This condition code indicates that the provider has been instructed by the state or local government agency that requested the healthcare items or services provided to the patient that it is the policy of the State or local government that the prisoner or patient is responsible to repay the cost of healthcare items and services and that it pursues collection of debts incurred for furnishing such items or services with the same vigor and in the same manner as any other debt.

Carrier/DMERC Claims Processing Procedures

Carriers and DMERCs must deny claims for items and services rendered to beneficiaries when rejected by CWF. Provide appeal rights as specified above.

Physicians and other suppliers that render services to a prisoner or patient in a jurisdiction that meets the conditions of 42 CFR 411.4(b) should indicate this fact on the claim. Providers should use the QJ modifier. Language approved for QJ reads:

"Services/items provided to a prisoner or patient in State or local custody, however, the State or local government, as applicable, meets the requirements in 42 CFR 411.4(b)."

This modifier indicates that the physician or other supplier has been instructed by the state or local government agency that requested the healthcare items or services provided to the patient that State or local law makes the prisoner or patient responsible to repay the cost of Medical services and that it pursues collection of debts incurred for furnishing such items or services with the same vigor and in the same manner as any other debt.

10.5 - Claims Processing Requirements for Deported Beneficiaries

(Rev. 943, Issued: 05-05-06; Effective Date: 06-05-06; Implementation Date: 08-07-06)

Section 202(n) of the Social Security Act (the Act), requires the termination of Title II benefits upon deportation. Moreover, Sections 226 and 226(A) of the Act provide that no payments may be made for benefits under Part A of Title XVIII of the Act if there is no monthly benefit payable under Title II. Section 1836 of the Act limits Part B benefits to those who are either entitled to Part A benefits or who are age 65 and a United States (U.S.) resident, U.S. citizen, or a lawfully admitted alien residing permanently in the U.S. Given that, a deported beneficiary is not allowed to enter the U.S. and cannot be lawfully present in the United States to receive Medicare-covered services, Medicare payment cannot be made for Part B Benefits.

An audit of Medicare payments by the Office of Inspector General identified a vulnerability for the Medicare trust fund with respect to this issue. The study identified improper payments for beneficiaries, who, on the date of service on the claim, had been deported. To address this vulnerability, CMS is establishing claim level editing using data from the Social Security Administration (SSA). Specifically, the data contains the name and Health Insurance Claim (HIC) of the Medicare beneficiary and the month the deportation is effective. CWF will reject claims where the effective date on the Master Beneficiary Record is equal to or greater than the date of service on the claim. All claims rejected by CWF shall be denied by the respective Carrier, DMERC, RHHI or intermediary that submitted the claim to CWF.

Policy:

Medicare payment shall not be made for an item or service furnished to an individual that has been deported from the United States.

Appeals:

A party to a claim denied in whole or in part under this policy may appeal the initial determination on the basis of the deportation status at the time the item or service was furnished.

10.5.1 - Implementation of Payment Policy for Deported Medicare Beneficiaries

(Rev. 943, Issued: 05-05-06; Effective Date: 06-05-06; Implementation Date: 08-07-06)

A. CWF Editing of Claims

1. An auxiliary file shall be established in the Common Working File to contain deportation status.

2. This auxiliary file will be the basis for an edit that rejects claims submitted by Medicare contractors.

3. The edit will reject a claim where the beneficiary HIC number on the claim matches the HIC number on the Master Beneficiary Record and the date of service is on or after the date of deportation.

B. Carriers/DMERCs

1. Carriers and DMERCs shall deny claims for items and services when rejected by CWF.

2. Carriers and DMERCs shall refer to the CWF documentation on this subject for the error code assigned to this editing.

3. Upon receipt of an error code that is specific to this edit, carriers and DMERCs shall use reason code 96, non-covered charges, with Remark Code N126 “Social Security

Records indicate that this individual has been deported. The payer does not cover items and services furnished to individuals who have been deported."

4. When CWF rejects a claim, carriers and DMERCs shall use MSN message #16.56 "Claim denied because information received from the Social Security Administration indicates that you have been deported." Spanish translation for 16.56 reads "La reclamación fue denegada porque la información proporcionada por la Administración del Seguro Social indica que usted ha sido deportado(a)."

5. All denials will provide appeal rights as specified in section 10.5.

C. Intermediaries/RHHIs

1. Intermediaries and RHHIs shall deny claims for items and services when rejected by CWF.

2. Intermediaries and RHHIs shall refer to the CWF documentation on this subject for the error code assigned to this editing.

3. Upon receipt of an error code that is specific to this edit, intermediaries and RHHIs shall use reason code 96, non-covered charges, with Remark Code N126 "Social Security Records indicate that this individual has been deported. The payer does not cover items and services furnished to individuals who have been deported."

4. When CWF rejects a claim on the basis that the beneficiary was deported on the date of service(s), intermediaries and RHHIs shall use MSN message #16.56 "Claim denied because information received from the Social Security Administration indicates that you have been deported." Spanish translation for 16.56 reads "La reclamación fue denegada porque la información proporcionada por la Administración del Seguro Social indica que usted ha sido deportado (a).

5. All denials will provide appeal rights as specified in section 10.5.

20 - *Provider Assignment to FIs and MACs*

(Rev. 1707; Issued: 03-27-09; Effective: 04-027-09; Implementation: 04-27-09)

A. The Process of Moving Providers from FIs to MACs

1. The General Case

An existing Medicare provider with a claims history will remain in its current workload assignment. As each MAC contract is awarded, the new MAC will take over workload from the carriers and FIs that serviced the state(s) in the given MAC jurisdiction. The Part A and Part B workload segments for each of the states in the given MAC jurisdiction will be moved one-by-one in the 12 months following the final award. The specific requirements associated with workload transfers will be directed through formal CMS transmittals.

A new provider (also known as an "initial enrollment") will be assigned to the FI or MAC that covers the state where the provider is located, unless the assignment is directed to a non-geographic workload by §20B below.

A special exception exists for a "Multi-Provider Complex/Sub-Unit" relationship (ref: 42 CFR 483.5(b)). An initial enrollment for a sub-unit will be assigned to the FI or MAC that currently serves the existing parent hospital – even if the parent hospital is not presently billing in accordance with the "geographic assignment rule." Each such case is fact-specific and will be treated on an individual basis.

2. Out of Jurisdiction Providers

An "out-of-jurisdiction provider" (OJP) is a provider that is <u>not</u> currently assigned to the A/B MAC or FI in accordance with §§B.1-5 below (including the geographic assignment rule.) For example, an individual, freestanding provider located in Maine, but currently assigned to the Wisconsin FI, would be an OJP.

Many legacy Part A workload segments may include a number of OJPs. Examples of how an OJP may have been assigned to the given Part A segment include:

a. Individual "provider nominations." (Note MMA §911 repealed the provider nomination provisions of the Act.);

b. Chains being granted "single FI" status; and

c. Legacy-world regional and national FIs for specific provider types such as FQHCs, RHCs, and ESRD facilities.

New MACs will initially service some OJPs until CMS undertakes the final reassignment of all OJPs to their destination MACs based on the geographic assignment rule and its exceptions.

CMS will start the overall transfer of OJPs to their final destination MACs after all 15 A/B MACs have been implemented. Each move will be dependent on the then-current implementation status of the systems that support the cost report audit, claims processing, and provider enrollment functions at the departure and destination MACs.

Some providers will need to submit or update their Medicare enrollment record before being reassigned.

B. The Settled MAC Environment

The "settled MAC environment" refers to the period after all OJPs have been moved to their destination MACs.

1. Home Health & Hospice

All home health and hospice (HH&H) providers will be assigned to the MAC contracted by CMS to administer HH&H claims for the geographic locale in which the provider is physically located.

2. Durable Medical Equipment

Each supplier of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) will submit claims to the DME MAC contracted by CMS to administer DMEPOS claims for the geographic locale in which the beneficiary permanently resides.

3. Qualified Railroad Retirement Beneficiaries Entitled to Medicare

Physicians and other suppliers (except for DMEPOS suppliers) will continue to enroll with and bill the contractor designated by the Railroad Retirement Board (under Section 1842(g) of The Act) for Part B services furnished to these beneficiaries. Suppliers of DMEPOS will bill the DME MACs.

4. Specialty Providers and Demonstrations

Specialty providers, and providers involved with certain demonstrations, will submit claims to a specific MAC designated by CMS. Examples of specialty providers and their corresponding MACs are:

Specialty Service	***MAC Jurisdiction***
Centralized Billing for Mass Immunizers	***4***
Indian Health Services/Federally Recognized Tribal Providers (Refer to Chapter 19 of this manual.)	***4***
Low Vision Demonstration	***5, 10, 11, 13, and 14***
Veterans Affairs Medicare Equivalent Remittance Advice Project	***4***
Home Health Third Party Liability Demonstration Project	***14***
Independent Organ Procurement Organizations	***10***
Religious Non-medical Health Care Institution (RNHCI)	***10***
Histocompatibility Lab	***10***

5. The Geographic-Assignment Rule

Medicare providers, physicians, and suppliers will generally be assigned to the A/B MAC that covers the state where the provider is located. This includes FQHCs, RHCs, and ESRD facilities.

An exception exists for qualified chain providers (QCPs). A QCP may request that its member providers be serviced by a single A/B MAC - specifically, the A/B MAC whose jurisdiction includes the QCP's home office. See 42 CFR 421.404 for QCP criteria and additional information.

A few providers that meet the "provider-based" criteria of 42 CFR 413.65 may present an additional exception to the geographic-assignment rule. Provider-based entities (other than HH+H providers) will be assigned to the MAC contracted by CMS to administer claims for the Medicare benefit category applicable to the provider's covered services for the geographic locale in which the main ("parent") provider is physically located.

20.1 - FI Service to HHAs and Hospices

(Rev. 1, 10-01-03)

A2-2807.B

Under 42 CFR 421.117, CMS is authorized to designate RHHIs to service HHAs and hospices. This provision was implemented through the designation of regional FIs to service all HHAs and hospices. See http://www.cms.hhs.gov/contacts/incardir.asp for RHHI jurisdictions.

An HHA or hospice chain may request to be served under an arrangement involving a lead FI serving its home office and regional FIs serving the individual facilities of the chain. Alternatively, a HHA or hospice chain may request to be served by a single designated regional intermediary. In either case, CMS does not grant requests automatically but rather requires the provider to demonstrate that the requested arrangement would be consistent with effective and efficient administration of the Medicare program.

For provider-based HHAs and hospices, audits, cost report settlements and other fiscal functions (such as setting interim payment rates) are performed by the FI serving the parent provider. The claims processing activities are performed by the designated RHHI for the provider.

20.2 - Provider Change of Ownership (CHOW)

(Rev. 861, Issued: 02-17-06; Effective: 10-01-05; Implementation: 03-17-06)

Providers (as defined in 1861(u) of the Act, and institutional suppliers such as RHCs) that undergo a change in their ownership structure are required to notify CMS concerning the identity of the old and new owners. They are also required to inform CMS on how they will organize the new entity and when the change will take place. A terminating cost report will be required from the seller owner in all CHOWs for certification purposes. There are five types of changes that can occur:

1. A CHOW in accordance with 42 CFR 489.18;

2. Changes in the ownership structure to an existing provider that do not constitute a CHOW;

3. A new owner who purchases a participating provider but elects not to accept the automatic assignment of the existing provider agreement, thus avoiding the old owner's Medicare liabilities;

4. An existing provider who acquires another existing provider (acquisition/merger); and

5. Two or more existing providers who are totally reorganizing and becoming a new provider (consolidation).

Providers that undergo a change of ownership will usually continue with the same FI that served the previous owner. However, if the prospective owner does not wish to accept the automatic assignment of the existing provider agreement, this means that the existing provider agreement is

terminated effective with the CHOW date. The regional office must be notified in writing of the CHOW per instructions contained in section 3210.5 of the State Operations Manual. The prospective owner provides a notice 45 -days in advance of the CHOW to the CMS/RO to allow for the orderly transfer of any beneficiaries that are patients of the provider. All reasonable steps must be taken to ensure that beneficiaries under the care of the provider are aware of the prospective termination of the agreement. There may be a period when the facility is not participating and beneficiaries must have sufficient time and opportunity to make other arrangement for care prior to the CHOW date.

After the CHOW has taken place, the RO acknowledges the refusal to accept assignment in a letter to the new owner, with copies to the State Agency (SA) and the FI. The RO completes a form CMS-2007 with the date the agreement is no longer in effect, noting that the termination is due to the new owner's refusal to accept assignment of the provider agreement.

If the new owner refuses to accept assignment and also wishes to participate in the Medicare program, the RO will first process the refusal as indicated above and then treat the new owner as it would any new applicant to the program. The RO will obtain and process the application documents, have the SA perform an initial survey and if all the requirements for participation are met, assign an effective date of participation. The earliest possible effective date for the applicant is the date that the RO determines that all Federal requirements are met. Once this is completed, a new provider agreement with a new provider number will be issued to the new owner. The provider will be assigned to the local FI.

See chapter 10, of the Medicare Program Integrity Manual, for complete requirements for completion of Form CMS-855 in change of ownership situations.

20.3 - Multi-State Provider Chains Billing FIs

(Rev. 861, Issued: 02-17-06; Effective: 10-01-05; Implementation: 03-17-06)

NOTE: The CMS does deny certain freestanding providers to become chain organizations, please refer to section. §20 for a list of these providers.

New providers that belong to CMS-recognized chains have the option of being assigned to the local designated FI or to the FI that serves the chain home office.

A centralized chain of providers may, because of the nature of its operations, require services through a single FI in order to improve administration. If a single FI would not be possible with the usual election procedures (e.g., the desired FI is not authorized to serve in some areas where the chain facilities are located), the chain may nevertheless request special authorization for the FI to serve all its component facilities. Such requests are submitted to the RO that has jurisdiction of the State in which the home office of the chain is located. The following factors will be considered, among others, in determining whether such authorization may be granted:

Size	The chain must comprise a minimum of ten participating facilities or 500 certified beds. However, where the chain has facilities in three contiguous States, it may be eligible if it comprises five facilities or 300 certified beds.
Central Controls	The chain must demonstrate that effective central controls are exercised assuring substantial uniformity in the operating procedures, utilization controls, personnel administration, and

	fiscal operations of the individual provider.
Savings or Efficiencies	The provider must demonstrate that the change is consistent with effective and efficient administration of the Medicare program. If the provider alleges that cost savings or other efficiencies will be realized; these must be quantified in terms of savings to the Government.
FI Capacity	Based on the chain's size and location of the individual facilities, the elected FI must be found to have the resources and capacity to effectively serve the chain. **NOTE:** If the HHA or Hospice chain chooses a single RHHI, the single RHHI services the entire chain and it also does the audit. The single designated RHHI handles the chain's home office audit, desk review and all of the chain's cost reports. The single designated RHHI determines the scope of individual provider audits and negotiates the final settlements for each cost report. The designated RHHI processes and pays claims as well as conducts medical field reviews. See 42 CFR 421.117(e). The CMS must review the request and determine whether the arrangement is in the best interest of the program. If the request is approved, the RO initiates all actions necessary to tie the multi-State chain to the FI/FIs.

20.4 - CMS No Longer Accepts Provider Requests to Change Their FI

(Rev. 861, Issued: 02-17-06; Effective: 10-01-05; Implementation: 03-17-06)

Medicare providers will no longer be able to request a change of FI, they must remain with the FI to which they have been assigned.

20.5 - Solicitation of a Provider to Secure a Change of FI

(Rev. 861, Issued: 02-17-06; Effective: 10-01-05; Implementation: 03-17-06)

If FIs solicit nominations from providers currently served by other FIs, the program suffers unnecessary disruption and cost. Consequently, FIs must refrain from such solicitation, and providers are asked to alert their RO whenever they become the object of such activity. Likewise, if an FI becomes aware that its providers are being solicited, it should discuss the circumstances with its RO.

Solicitation is defined as "**an FI taking the initiative in furnishing to any Medicare provider presently served by another FI, information, promises, projections, or other material intended to cause the provider to seek CMS' approval for a change of FI**."

The RO serving the provider involved will investigate allegations of solicitation. Where CMS determines that an FI did solicit a provider's nomination contrary to these instructions, the FI will be barred from servicing that provider. Additionally, periods of geographic suspension of availability for provider service may be imposed upon an offending FI on a State, regional, or nationwide basis depending on the frequency and nature of the complaints.

20.5.1 - Communications

(Rev. 861, Issued: 02-17-06; Effective: 10-01-05; Implementation: 03-17-06)

If an FI receives a request for Medicare material or information from a provider serviced by another FI, it may comply with the request only after first notifying its servicing RO in writing that the request has been received. If the provider requests a visit by the FI, CMS considers a single visit sufficient to make a presentation; however, the RO may authorize multiple visits if the FI furnishes sufficient justification. For each contact or visit it has with a provider it does not service, the purpose of which is to discuss the Medicare program, the FI is expected to maintain a file of written reports.

30 - Provider Participation

(Rev. 1, 10-01-03)

A2-2810

The RO uses the provider tie-in notice, Form CMS-2007 (see the CMS forms page at http://www.cms.hhs.gov/forms/), as an official notification to the FI of a change in its list of providers. The RO completes and transmits a Form CMS-2007 to the home office of the FI in each of the following circumstances:

- A provider is certified for participation in the program,
- A provider is issued a notice of termination,
- A change of FI is authorized (including changes between Blue Cross plans or between FI processing facilities, i.e., any changes involving a change in the FI number), or
- To correct information previously furnished the FI.

Part I of the Form CMS-2007, Identifying Information, identifies the provider and is always completed.

Part II, New Provider Certification, is completed where the provider is certified (including certifications required because of a change of ownership).

Part III, Change of FI, is completed where a change of FI has been authorized.

Part IV, Terminations, is completed in all termination actions.

Part V, Remarks, will be used for additional clarifying information.

The FI must promptly notify the RO of any information found to be incorrect. The RO will issue a corrected Form CMS-2007.

30.1 - Content and Terms of Provider Participation Agreements

(Rev. 1, 10-01-03)

A2-2840, RHC-320

In the agreement/attestation statement signed by a provider serviced by an FI, the provider agrees to maintain its compliance with all of the conditions for certification in 42 CFR 491. If a provider fails to maintain compliance with one or more of the conditions, it must promptly report this (usually within 30 days of the failure) to the responsible CMS office or official. Failure to report promptly may be a cause for termination of the provider's agreement.

30.1.1 - Provider Charges to Beneficiaries
(Rev. 1522, Issued: 05-30-08, Effective/Implementation: 06-30-08)

In the agreement/attestation statement signed by a provider, it agrees not to charge Medicare beneficiaries (or any other person acting on a beneficiary's behalf) for any service for which Medicare beneficiaries are entitled to have payment made on their behalf by the Medicare program. This includes items or services for which the beneficiary would have been entitled to have payment made had the provider filed a request for payment (see §50).

The provider may bill the beneficiary for the following items:

- Part A deductible;
- Part B deductible;
- First 3 pints of blood, which is called the blood deductible (if there is a charge for blood or the blood is not replaced);
- Part B coinsurance;
- Part A coinsurance; or
- Services that are not Medicare covered services. See Chapter 30 for related requirements.

SNFs may not require, request, or accept a deposit or other payment from a Medicare beneficiary as a condition for admission, continued care, or other provision of services, except as follows:

- A SNF may request and accept payment for a Part A deductible and coinsurance amount on or after the day to which it applies.
- A SNF may request and accept payment for a Part B deductible and coinsurance amount at the time of or after the provision of the service to which it applies.
- A SNF may not request or accept advance payment of Medicare deductible and coinsurance amounts.
- A SNF may require, request, or accept a deposit or other payment for services if it is clear that the services are not covered by Medicare and proper notice is provided. See Chapter 30 for instructions about ABNs and demand bills.
- SNFs, but not hospitals, may bill the beneficiary for holding a bed during a leave of absence if the requirements in §30.1.1.

30.1.1.1 - Charges to Hold a Bed During SNF Absence
(Rev. 1522, Issued: 05-30-08, Effective/Implementation: 06-30-08)

Charges to the beneficiary for admission or readmission are not allowable. However, when temporarily leaving a SNF, a resident can choose to make bed-hold payments to the SNF.

Bed-hold payments are readily distinguishable from payments made prior to initial admission, in that the absent individual has already been admitted to the facility and has established residence in a particular living space within it. Similarly, bed-hold payments are distinguishable from payments for readmission, in that the latter compensate the facility merely for agreeing in advance to allow a departing resident to reenter the facility upon return, while bed-hold payments represent remuneration for the privilege of actually maintaining the resident's personal effects in the particular living space that the resident has temporarily vacated.

One indicator that post-admission payments do, in fact, represent permissible bed-hold charges related to maintaining personal effects in a particular living space (rather than a prohibited charge for the act of readmission itself) would be that the charges are calculated on the basis of a per diem bed-hold payment rate multiplied by however many days the resident is absent, as opposed to assessing the resident a fixed sum at the time of departure from the facility.

Under §1819(c)(1)(B)(iii) of the Act and 42 CFR 483.10(b)(5)-(6), the facility must inform residents in advance of their option to make bed-hold payments, as well as the amount of the facility's charge. For these optional payments, the facility should make clear that the resident must affirmatively elect to make them prior to being billed. A facility cannot simply deem a resident to have opted to make such payments and then automatically bill for them upon the resident's departure from the facility.

30.1.2 - Provider Refunds to Beneficiaries

(Rev. 1, 10-01-03)

RHC-322

In the agreement between CMS and a provider, the provider agrees to refund as promptly as possible any money incorrectly collected from Medicare beneficiaries or from someone on their behalf.

Money incorrectly collected means any amount for covered services that is greater than the amount for which the beneficiary is liable because of the deductible and coinsurance requirements.

Amounts are considered to have been incorrectly collected because the provider believed the beneficiary was not entitled to Medicare benefits but:

- The beneficiary was later determined to have been entitled to Medicare benefits;
- The beneficiary's entitlement period fell within the time the provider's agreement with CMS was in effect; and
- Such amounts exceed the beneficiary's deductible, coinsurance or non covered services liability.

30.1.3 - Provider Treatment of Beneficiaries

(Rev. 1, 10-01-03)

RHC-323

In the agreement between CMS and a provider, the provider agrees to accept Medicare beneficiaries for care and treatment. The provider cannot impose any limitations with respect to care and treatment of Medicare beneficiaries that it does not also impose on all other persons seeking care and treatment. If the provider does not furnish treatment for certain illnesses and conditions to patients who are not Medicare beneficiaries, it need not furnish such treatment to Medicare beneficiaries in order to participate in the Medicare program. It may not, however, refuse to furnish treatment for certain illnesses or conditions to Medicare beneficiaries if it furnishes such treatment to others. Failure to abide by this rule is a cause for termination of the provider's agreement to participate in the Medicare program

30.2 - Assignment of Provider's Right to Payment

(Rev. 1, 10-01-03)

A3-3488, A3-3703.1, B3-3060

Except as provided in §30.2.1, FIs pay benefits due a provider only to the provider.

Carriers may pay assigned benefits only to the physician, practitioner, or supplier who furnished the service. They do not pay the benefits to any other person or organization under an assignment or reassignment, power of attorney, or under any other arrangement in which the other person or organization receives the payment directly. For this purpose, assigned benefits include, in addition to the benefits usually encompassed by this term, benefits payable after the death of the enrollee to the physician or other supplier on the basis of his agreement to accept the reasonable charge as the full charge. A power of attorney for this purpose means a written authorization by a principal to an agent:

- To receive in the agent's own name amounts due the principal;
- To negotiate checks payable to the principal; or
- To receive in any other manner direct payment of amounts due the principal.

The prohibition against assignment of a provider's benefits also applies to payment of benefits due a provider as a reassignee of the physician.

Payment is considered to be made directly to an ineligible person or organization if that person or organization can convert the payment to its own use and control without the payment first passing through the control of the provider or other party eligible to receive the payment under the exceptions in §30.2.1. (For payment to a bank, see §30.2.5.)

Forwarding of amounts due a provider to its home office is not affected by the prohibition described in this section. Reimbursement amounts for providers of a chain organization may be forwarded to a central location of the home office when it has set up a lock box or special bank account and the FI has secured a **written** assignment or other authorization from the respective provider(s) that payment may be sent to the home office. The payments must be made out in the individual provider's name and payment may be made by check or electronic funds transfer (EFT).

Establishment of internal controls and other related administrative details necessary to effect these payments are left to the individual contractors involved. However, FIs must be sure that the individual signing the assignment can legally bind the provider. Payment under those procedures is payment to the provider.

30.2.1 - Exceptions to Assignment of Provider's Right to Payment - Claims Submitted to FIs and Carriers

(Rev. 472, Issued: 02-11-05, Effective: 01-01-05, Implementation: 03-15-05)

A. Payment to Government Agency

Medicare payment for the services of a provider is not made to a governmental agency or entity except when payment to the governmental agency or entity is permissible under the other listed reassignment exceptions, e.g., where the agency is the employer of the physician.

B. Payment Pursuant to Court Order

The Medicare program may make payment in accordance with an assignment established by, or pursuant to the order of, a court of competent jurisdiction. The assignment must satisfy the conditions set forth in §30.2.

C. Payment to Agent

The Medicare program may make payment, in the name of the provider, to an agent who furnishes billing or collection services. The payment arrangement must satisfy the conditions in §30.2.4.

D. Payment to Employer

The carrier may pay the employer of the physician or other supplier if the physician or other supplier is required, as a condition of his employment, to turn over to his employer the fees for his services. (See §30.2.6.)

E. Payment for Services Provided Under a Contractual Arrangement

The carrier may make payment to an entity enrolled in the Medicare program for services provided by a physician or other person under a contractual arrangement with that entity. The services may be furnished on or off the premises of the entity submitting the claim. Both, the entity submitting the claim and receiving payment and the physician or other person under contract are subject to certain program integrity requirements. (See §30.2.7.)

F. Payment to Physician for Purchased Diagnostic Tests

The carrier may pay a physician (or a physician's medical group) for diagnostic laboratory tests (other than clinical diagnostic laboratory tests), which that physician (or group) purchases from an independent physician, medical group, or other supplier. Cannot mark-up the test. Must accept as payment in full the lower of the purchase price or the fee schedule amount. (See §30.2.9.)

G. Payment to Supplier for Diagnostic Test Interpretations

The carrier may pay a person or entity that provides diagnostic tests for purchased diagnostic test interpretations, which that person or entity purchases from an independent physician or medical group, if specified requirements are met. Three separate entities: (1) ordering entity, (2) entity furnishing the diagnostic test, and (3) entity doing the test interpretation. (See §30.2.9.1.)

H. Payment Under Reciprocal Billing Arrangements

The carrier may pay the patient's regular physician for services provided to his/her patients by another physician on an occasional reciprocal basis. (See §30.2.10.)

I. Payment Under Locum Tenens Arrangements

The carrier may pay the patient's regular physician for services of a locum tenens physician during the absence of the regular physician where the regular physician pays the locum tenens on a per diem or similar fee-for-time basis, and certain other requirements are met. (See §30.2.11.)

30.2.2 - Background and Purpose of Reassignment Rules - Claims Submitted to Carriers

(Rev. 1, 10-01-03)

In 1972, Congress acted to stop a practice under which some physicians and other suppliers providing covered services reassigned their Medicare and Medicaid receivables to other organizations and groups, which then claimed and received payment. Often the organizations purchased the claims at a percentage of face value. It had become apparent that such reassignments were a source of incorrect, inflated, and even fraudulent Medicare and Medicaid claims. The Social Security Act Amendments of 1972, Public Law 92-603, enacted a prohibition against payment on a charge basis for covered services to anyone other than the patient, physician or other person who provided the service, with limited exceptions.

Thereafter, some physicians and other suppliers circumvented the intent of the law by granting a power of attorney. This allowed the factoring company or other person to receive the Medicare or Medicaid payments in the name of the physician or other supplier, thus permitting continuation of program abuses.

Section 2(a) of Public Law 95-142, dated October 25, 1977, modified existing law to preclude the use of power of attorney as a device for reassignment of benefits under Medicare, subject to limited exceptions. It also provides for a similar prohibition with respect to payment for care furnished by providers.

These provisions preclude Medicare payment of amounts due a provider or other person to a person or entity furnishing financing to the provider, whether the provider sells the provider's claims to that person or entity or pledges them to that person or entity as collateral on a loan.

A. Who is Supplier of Services

The question of reassignment arises only when assigned payment is made to someone other than the physician or other practitioner or supplier that furnished the services.

A supplier may be an individual, partnership, corporation, trust, or estate. Any services furnished by an employee of the supplier are considered furnished by the supplier if those services are within the scope of the employment. Where the supplier is a partnership, any services furnished by a partner are considered furnished by the supplier if those services are within the scope of the partnership agreement. Therefore, issues of reassignment are limited to claims submitted to carriers.

Services that one physician or other supplier purchases from another are not usually considered furnished by the purchasing supplier for purposes of the prohibition on reassignment. See §§30.2.9-30.2.9.1 for exceptions.

When one supplier purchases or rents items (as distinguished from services) from another supplier and resells or re-rents those items to the beneficiary, no reassignment issue arises. The supplier that sells or rents the items to the beneficiary is considered to furnish them.

In the case of drugs used in conjunction with durable medical equipment (DME) or prosthetic devices, the entity that dispenses the drug must furnish it directly to the patient for whom a

prescription is written. Therefore, those drugs cannot be purchased for resale to the beneficiary by any supplier that is not the entity that dispenses the drugs. Such a supplier may only bill for the DME or prosthetic devices. In order for prescription drugs that are used in conjunction with DME or prosthetic devices to be covered by Medicare, the entity that dispenses the drugs must have a Medicare supplier number, must be licensed to dispense the drug in the State in which the drug is dispensed, and must bill and receive payment in its own name.

B. Effect of Payment to Ineligible Recipient

An otherwise correct Medicare payment made to an ineligible recipient under a reassignment or other authorization by the physician or other supplier does not constitute a program overpayment. Sanctions may be invoked under §30.2.15 against a physician or other supplier to prevent him from executing or continuing in effect such an authorization in the future, but neither the physician nor other supplier nor the ineligible recipient is required to repay the Medicare payment. See Chapter 10 of the Medicare Program Integrity Manual for appeal rights of physicians and physician groups when billing numbers are revoked for non-compliance with the reassignment rules. Appeal rights for prospective and existing providers can be found at 42 CFR §498 of the Medicare regulations.

C. Effect of Reassignment on Assignment Agreement

A3-3045.1

An assignment is an agreement between a physician (or other supplier of services) and an enrollee where the enrollee transfers to the physician his/her right to benefits based on covered services specified on the assigned claim. The physician in return agrees to accept the approved charge determination by the carrier as his/her full charge for the items or services. In effect, the physician who accepts assignment is precluded from charging the enrollee more than the deductible and coinsurance based upon the approved charge determination.

When a qualified entity accepts assignment for a service furnished by a physician (thereby agreeing to collect no more than the Medicare deductible and coinsurance based on the allowed amount from the beneficiary), it is the entity and not the physician that is found by the terms of the assignment. In this situation, the physician may accept from the entity a set fee or other payment that is greater than the reasonable charge, without violating the terms of the assignment. If the entity pays the physician such amount, the entity must absorb any loss resulting from the excess of the payment to the physician over the reasonable charge. An entity may accept assignment for a physician's services only if the employment or other contractual arrangement between the entity and the physician provides that it alone has the right to bill and receive the payment for the services. The beneficiary is fully protected against any liability for the difference between the reasonable charge and any higher fee owed by the entity to the physician, since only the entity may collect from the beneficiary, and then only in the amount of the applicable deductible and coinsurance.

When a physician or nonphysician practitioner opts out of the Medicare program and is a member of a group practice or otherwise reassigns his or her right to bill and receive Medicare payment to an organization, the organization may no longer bill Medicare or receive Medicare payment for the services that the physician or nonphysician practitioner furnishes to Medicare beneficiaries. However, if the physician or nonphysician practitioner continues to grant the organization with the right to bill and receive payment for the services he or she furnishes to patients, the organization may bill and be paid by the beneficiary for the services that are provided under the private contract. In addition, the decision of a physician or nonphysician

practitioner to opt out of Medicare does not affect the ability of the group practice or organization to bill Medicare for the services of physicians and/or nonphysician practitioners who have not opted out of Medicare.

Suppliers not enrolled in Medicare may not receive payment.

30.2.2.1 - Reassignments by Nonphysician Suppliers - Claims Submitted to FIs

(Rev. 1, 10-01-03)

Definition of Participating From MIM 3005

Nonphysician suppliers may reassign benefits under conditions similar to those under which physicians reassign benefits. Note, however, that when a supplier furnishes services to patients of a participating provider (e.g., a participating hospital or SNF) under arrangement (within the meaning of §1861(w) of the Act), the provider, not the supplier, is reimbursed by Medicare. No reassignment is involved since the provider is then responsible for paying subcontracting providers/suppliers under these payment structures.

To be a **participating** provider under Medicare, a provider must be in compliance with the applicable provisions of title VI of the Civil Rights Act of 1964 and must enter into an agreement under §1866 of the Act which provides that it (1) will not charge any individual or other person for items and services covered by the health insurance program other than allowable charges and deductibles and coinsurance amounts; and (2) will return any money incorrectly collected from the individual or other person on his behalf or make such other disposition as described in §30.1 (See also §30.1 on participation agreements).

30.2.3 - Effect of Payment to Ineligible Recipient

(Rev. 1, 10-01-03)

An otherwise correct Medicare payment made to an ineligible recipient under an assignment or other authorization by the provider does not constitute a program overpayment. Sanctions may be invoked against a provider (see §30.2.15) to prevent it from executing or continuing in effect such an authorization in the future. Neither the provider nor the ineligible recipient is required to repay the Medicare payment.

30.2.4 - Payment to Agent - Claims Submitted to Carriers

(Rev. 1, 10-01-03)

A3-3488.1, B3-3060.10

A. Conditions

The FI or carrier makes payment **in the name of the provider** (Carriers additionally may pay in the name of supplier or employer, facility, or organized health care delivery system.) to an agent who furnishes billing or collection services if:

- The agent receives the payment under an agreement between the provider and the agent;
- The agent's compensation is not related in any way to the dollar amount billed or collected;
- The agent's compensation is not dependent upon the actual collection of payment;
- The agent acts under payment disposition instructions which the provider may modify or revoke at any time; and

- In receiving the payment, the agent acts only on behalf of the provider (except insofar as the agent uses part of that payment to compensate the agent for the agent's billing and collection services).

For this purpose, an agency is an entity that provides computer and other billing services to prepare claims, and receive and process Medicare benefit checks for the provider, supplier, physician or other practitioner.

B. Background

The primary purpose of this exception is to permit computer and other billing services to claim and receive Medicare payment on behalf of and in the name of the provider, supplier or eligible party). The conditions for payment insure that the billing agent has no financial interest in how much is billed or collected and is not acting on behalf of someone who has such an interest, other than the provider/supplier itself.

The conditions specified in subsection A do not apply if the agent merely prepares bills for the provider and does not receive and negotiate the checks payable to the provider/supplier.

The conditions specified in subsection A also do not apply where the entity receiving payment in the name of the physician qualifies to receive payment for the physician's services by definition in law and regulations. Thus, a hospital which is entitled to bill and receive payment in its name for a physician's service under §30.2.7 may bill and receive payment in the physician's name (negotiating the checks under a power of attorney) even though its compensation is related to the amount billed or collected or is dependent on collection.

C. Documentation

If payment is being made or requested to be made in the name of a provider to an agent, the contractor assumes that the conditions for such payment are met in the absence of evidence to the contrary. If there is evidence to the contrary, the agent must document the agreement by submitting to the contractor a copy of the written agreement. The written agreement may be a formal legal document or merely an exchange of correspondence. If there is no written agreement of either a formal or informal nature or all the required conditions for payment are not clear in the agreement, the contractor obtains a statement from the agent describing the pertinent terms of the agreement or of those provisions that need to be clarified. The contractor verifies the agent's allegations by obtaining statements from one or more providers/physicians/suppliers that have agreements with the agent. See §30.2.14.1.D for reviewing endorsements on benefit checks.

30.2.5 - Payment to Bank

(Rev. 213, 06-25-04)

A3-3488.2, B3-3060.11

Medicare payments due a provider or supplier of services may be sent to a bank (or similar financial institution) for deposit in the provider/supplier's account so long as the following requirements are met:

- The bank may provide financing to the provider/supplier, as long as the bank states in writing, in the loan agreement, that it waives its right of offset. Therefore, the bank may have a lending relationship with the provider/supplier and may also be the depository for Medicare receivables; and

- The account is in the provider/supplier's name only and only the provider/supplier may issue any instructions on that account. The bank shall be bound by only the provider/supplier's instructions. No other agreement that the provider/supplier has with a third party shall have any influence on the account. In other words, if a bank is under a standing order from the provider/supplier to transfer funds from the provider/supplier's account to the account of a financing entity in the same or another bank and the provider/supplier rescinds that order, the bank honors this rescission notwithstanding the fact that it is a breach of the provider/supplier's agreement with the financing entity.

Irrespective of the language in any agreement a provider/supplier has with a third party that is providing financing, that third party cannot purchase the provider/supplier's Medicare receivables.

Subject to the above restrictions on the bank and to the bank's meeting the conditions specified in §30.2.4, a bank which is the provider/supplier's billing agent pursuant to an agreement with the provider/supplier and receives and deposits in the provider/supplier's bank account the provider/supplier's Medicare payments may, subject to instructions from the provider/supplier, draw on those funds to pay for its billing services.

Subject to the above restrictions on the bank, the provider/supplier's billing agent, other than the bank, that meets the conditions specified in §30.2.4 and receives and deposits in the provider/supplier's bank account the provider/supplier's Medicare payments may, subject to instructions from the provider/supplier, draw on these funds to pay for its billing services.

Notwithstanding the above restrictions, if a court of competent jurisdiction orders the assignment or reassignment of Medicare payments, Medicare will follow that order if, as stated in 42 C.F.R. §424.73(b)(2) and listed in 42 C.F.R. §424.90, a certified copy of the court order and of the executed assignment or reassignment (if it was necessary to execute one) is filed with the contractor responsible for processing the claim and the assignment or reassignment (1) applies to all Medicare benefits payable to a particular person or entity during a specified or indefinite time period; or, (2) specifies a particular amount of money, payable to a particular person or entity by the particular contractor. In all other instances, the Medicare program will make payments subject to the restrictions listed above. For example, even if a court order directed to a provider/supplier limits the provider/supplier's ability to breach its financial agreement with a third party, the bank is bound by instructions from the provider/supplier.

30.2.6 - Payment to Employer of Physician - Carrier Claims Only

(Rev. 1, 10-01-03)

B3-3060.1

The carrier may pay Part B benefits for covered physician services under an assignment or for enrollees that did not execute assignment before death to the physician's employer, provided that under the terms of the physician's employment, only the employer and not the physician has the right to charge or collect charges for the physician's services, and certain other conditions and limitations described below are met. There must be an employer-employee relationship between the physician and the person or organization hiring the physician to perform services, and the terms of the employment must provide that the employer and not the physician has the right to receive the payment for all the latter's services within the scope of the employment. If the employer has the right, as a condition of employment, to fees for all professional services the

physician renders, including those outside the scope of the employment, honor an assignment of benefits to the employer for all such services.

An employer may establish that it qualifies to receive payment for the services of its physicians by submitting the Form CMS-855R.

The employer must provide evidence that the employee is a valid employee by providing the carrier with a Form W-2 or other acceptable Internal Revenue Service documentation (a pay stub would suffice for new employees who do not yet have a Form W-2.).

30.2.7 - Payment for Services Provided Under a Contractual Arrangement - Carrier Claims Only

(Rev. 472, Issued: 02-11-05, Effective: 01-01-05, Implementation: 03-15-05)

A carrier may make payment to an entity (i.e., a person, group, or facility) enrolled in the Medicare program that submits a claim for services provided by a physician or other person under a contractual arrangement with that entity, regardless of where the service is furnished. Thus, the service may be furnished on or off the premises of the entity submitting the bill and receiving payment. The entity receiving payment and the physician or other person that furnished the service are both subject to the following program integrity safeguard requirements:

1. The entity receiving payment and the person that furnished the service are jointly and severally responsible for any Medicare overpayment to that entity; and,

2. The person furnishing the service has unrestricted access to claims submitted by an entity for services provided by that person.

30.2.8.2 - University-Affiliated Medical Faculty Practice Plans - Claims Submitted to Carriers

(Rev. 1, 10-01-03)

B3-3060.3.D

A carrier may make Part B payment to a university-affiliated medical faculty practice plan that has the following attributes:

- There is a written agreement between the Governing Board of the University and the Governing Board of the Medical Faculty Practice Plan describing the relationship between both parties.
- The Medical Faculty Practice Plan is a 501(c)(3) nonprofit tax-exempt organization, according to IRS regulations.
- Physicians of the faculty practice plan are employees of the University and/or medical school. The plan should furnish a copy of the employment agreement(s) between the faculty physician and the University.
- Physicians are full or part-time faculty members of the University's School of Medicine, licensed to practice medicine in the State.
- The faculty practice plan may only be affiliated with one University, and this relationship is described in the written agreement between the University and the Medical Faculty Practice Plan.

- Members of the faculty practice plan are represented on the Governing Board of the practice plan. The Board has the authority to make or delegate management and operational decisions on behalf of the physicians participating in the practice plan.
- Faculty practice plan physicians have unrestricted access to the billing records, medical documentation, and claims forms for services submitted on their behalf by the practice plan. The faculty practice plan provides documentation establishing the existence of this policy.
- The physicians abide by the rules and regulations of the Medical Faculty Practice Plan.
- The faculty practice plan is accountable to Medicare for any claims that are submitted on behalf of the plan's physicians for services provided to Medicare beneficiaries. Thus, the plan is responsible for refunding any overpayments to Medicare that are collected on behalf of the plan's physicians.

Both the Medical Faculty Practice Plan and the plan's physicians must enroll in the Medicare program by completing the Form CMS-855B and Form CMS-855R (Medicare health care provider/supplier enrollment application forms). Instructions for processing Form CMS-855B are referenced in Program Integrity Manual.

For those entities that are part of the organizational structure of the University, see §30.2.12, on payment to special accounts. These entities may include departments, specialties, practice plans, or similar subdivisions of a university or medical school.

30.2.8.3 - Managed Care Organization, Including HCPPs, Cost-Contracting HMOs, CMPs, and Medicare + Choice Organizations - Claims Submitted to Carriers

(Rev. 1, 10-01-03)

B3-3060.3.E, B3-7065

Carriers may make reassigned Part B payments under limited circumstances to health care pre-payment plan (HCPPs), cost-contracting HMOs, competitive medical plans (CMPs), and to Medicare+Choice Organizations.

A Medicare+Choice Organization is an entity that meets the following criteria:

- Is a public or private entity licensed by a state as a risk-bearing entity (with the exception of a provider-sponsored organization receiving a Federal waiver from state licensure requirements) that is certified by CMS as meeting the Medicare + Choice contract requirements;
- Is responsible for the organization, financing, administration, and contracting for the delivery of covered Part A and Part B services on a prepayment arrangement basis (HCPP agreements are only for Part B services); and
- Arranges for the provision of Medicare+Choice plan(s) (health benefits coverage offered under a policy or contract) services to enrolled Medicare beneficiaries residing in the service area of the Medicare+Choice plan(s).

The following are circumstances under which payments may be made by a carrier to an HCPP, a cost-contracting HMO, a CMP, or a Medicare+Choice organization:

1. The services are furnished to a beneficiary who is not a Medicare enrollee of the HCPP, HMO, or CMP, or Medicare+Choice organization;
2. The services are furnished to a beneficiary who is a Medicare enrollee of the HCPP, HMO, CMP, or Medicare+Choice organization, but who has not been added to CMS rolls as such;
3. The services are furnished to a beneficiary who is a Medicare enrollee of an HCPP, cost-contracting HMO, or CMP, but the services must be billed to the carrier because they are subject to certain administrative billing restrictions, e.g., independent physical therapy, blood, and end stage renal disease services;
4. The services, in the nature of attending physician services or services unrelated to a terminal illness, are furnished to a Medicare enrollee of a Medicare+Choice organization who has elected the hospice benefit, or,

The services are furnished by a Medicare+Choice organization to a Medicare enrollee, but are excluded from it's Medicare+Choice contract under §1852(a)(5) of the Act.

When an HCPP, HMO, CMP, or Medicare+Choice organization pays the physician, medical group, or other supplier on a fee-for-service basis, and conditions 2, 3, or 4 above are met, it may claim and receive payment from the carrier for the services under the indirect payment procedure described in the following paragraphs if it is approved as a qualified organization under that section and the other conditions for payment are met.

Medicare Part B payment otherwise payable to an enrollee for the services of a physician or supplier who charges on a fee-for-service basis may be paid to an entity:

- Which provides coverage of the service under a health benefits plan, but only to the extent that payment is not made under Part B (i.e., the coverage which the plan provides is complementary to Medicare and covers only the amount by which the Part B payment falls short of the charge approved under the plan for the service);
- Which pays the person who provided the services (or his reassignee) an amount which that person accepts as full payment; and
- Which has the written authorization of the beneficiary (or his representative) to receive the Part B payment.

This procedure formerly known as "payment to organizations" (PTO) is now called the "indirect payment procedure."

The indirect payment procedure provides an effective and efficient method of settling Medicare and complementary insurance liabilities where the complementary insurer in no case imposes any deductible and coinsurance for the service, in all cases is liable under the terms of the plan for the full difference between the Medicare benefit and the approved charge of the insurer for the service, and the physician or supplier is prepared to accept the insurer's approved charge as full payment for the service. In this situation, the indirect payment procedure permits the physician or supplier to file a single claim and receive full payment in a single check, relieves the beneficiary of the need to file a claim, and protects the beneficiary against any financial liability for the service.

30.2.9 - Payment to Physician or Other Supplier for Purchased Diagnostic Tests - Claims Submitted to Carriers

(Rev. 1250, Issued: 05-25-07, Effective: 10-01-07, Implementation: 10-01-07)

A physician or a medical group may submit the claim and (if assignment is accepted) receive the Part B payment, for the technical component of diagnostic tests which the physician or group purchases from an independent physician, medical group, or other supplier. (This claim and payment procedure does not extend to clinical diagnostic laboratory tests.) The purchasing physician or group may be the same physician or group as ordered the tests or may be a different physician or group. An example of the latter situation is when the attending physician orders radiology tests from a radiologist and the radiologist purchases the tests from an imaging center. The purchasing physician or group may not markup the charge for a test from the purchase price and must accept the lowest of the fee schedule amount if the supplier had billed directly; the physician's actual charge; or the supplier's net charge to the purchasing physician or group, as full payment for the test even if assignment is not accepted. (See section 10.1.1.2 for additional information on purchased diagnostic tests.)

In order to purchase a diagnostic test, the purchaser must perform the interpretation. The physician or other supplier that furnished the technical component must be enrolled in the Medicare program. No formal reassignment is necessary.

Effective for claims received on or after April 1, 2004:

- In order to have appropriate service facility location ZIP code and the purchase price of each test on the claim, when billing for purchased tests on the Form CMS-1500 paper claim form each test must be submitted on a separate claim form. Treat paper claims submitted with more than one purchased test as unprocessable per §80.3.2.

- More than one purchased test may be billed on the ANSI X12N 837 electronic format. When more than one test is billed, the total purchased service amount must be submitted for each service. Treat claims received with multiple purchased tests without line level total purchased service amount information as unprocessable per §80.3.2.

- Treat paper claims submitted for purchased services with both the interpretation and the purchased test on one claim as unprocessable per §80.3.2 unless the services are submitted with the same date of service and same place of service codes. When a claim is received that includes both services, and the date of service and place of service codes match, assume that the one address in Item 32 applies to both services. Effective for claims with dates of service on or after April 1, 2005, each component of the test must be submitted on a separate claim form. Treat paper claims with dates of service after March 31, 2005 submitted with more than one purchased test as unprocessable per §80.3.2.

- ANSI X12N 837 electronic claims submitted for purchased services with both the interpretation and purchased test on the same claim must be accepted. Assume that the claim level service facility location information applies to both services if line level information is not provided.

In order to price claims correctly and apply purchase price limitations, global billing is not acceptable for claims received on the Form CMS-1500 or on the ANSI X12N 837 electronic format. Each component must be billed as a separate line item (or on a separate claim per the

limitations described above). Treat the claim as unprocessable per §80.3.2 when a global billing is received and there is information on the claim that indicates the test was purchased.

Effective for claims with dates of service on or after January 25, 2005, carriers must accept and process claims for purchased diagnostic tests when billed by suppliers (including laboratories, physicians, and independent diagnostic testing facilities [IDTFs]) enrolled in the carrier's jurisdiction, regardless of the location where the service was furnished. Effective April 1, 2005, carriers must price purchased diagnostic test claims based on the ZIP code of the location where the service was rendered when billed by a laboratory or an IDTF, using a CMS-supplied national abstract file of the Medicare MPFS containing the HCPCS codes that are payable under the MPFS as either a purchased test or interpretation for the calendar year. Effective for claims with dates of service on or after October 1, 2007, carriers/Medicare Administrative Contractors (MACs) must use the national abstract file to price all claims for purchased diagnostic services, for all provider specialty types (including physicians), based on the ZIP code of the location where the service was rendered, in accordance with the carrier jurisdictional pricing rules specified in §10.1.1. (See IOM Publication 100-04, chapter 23, §30.6, and Addendum for record layouts and instructions for downloading the Abstract File for Purchased Diagnostic Tests/Interpretations.)

NOTE: As with all services payable under the MPFS, the ZIP code is used to determine the appropriate payment locality and corresponding fee for the purchased test/interpretation. When a ZIP code crosses locality lines, CMS uses the dominant locality to determine the corresponding fee.

30.2.9.1 - Payment to Supplier of Diagnostic Tests for Purchased Interpretations

(Rev. 1250, Issued: 05-25-07, Effective: 10-01-07, Implementation: 10-01-07)

A person or supplier that provides diagnostic tests may submit the claim, and (if assignment is accepted) receive the Part B payment, for diagnostic test interpretations which that person or entity purchases from an independent physician or medical group if:

- The tests are initiated by a physician or medical group which is independent of the person or entity providing the tests and of the physician or medical group providing the interpretations;

- The physician or medical group providing the interpretations does not see the patient; and

- The purchaser (or employee, partner, or owner of the purchaser) performs the technical component of the test. The interpreting physician must be enrolled in the Medicare program. No formal reassignment is necessary.

The purchaser must keep on file the name, the National Provider Identifier and the address of the interpreting physician. The rules permitting claims by a facility or clinic for services of an independent contractor physician on the physical premises of the facility or clinic are set forth in §§30.2.7 and 30.2.8.3.

NOTE: This change does not negate the requirement that when an entity either purchases an interpretation or a test, they themselves must perform the other component in order to be paid for the purchased component.

Effective for claims with dates of service on or after January 25, 2005, carriers must accept and process claims for purchased diagnostic interpretations billed by suppliers (including laboratories, physicians, and independent diagnostic testing facilities [IDTFs]) enrolled in the carrier's jurisdiction, for services furnished anywhere in the United States. Effective April 1, 2005, carriers must price claims for purchased interpretations based on the ZIP code of the location where the service was rendered when submitted by a laboratory or IDTF, using a CMS-supplied national abstract file of the MPFS containing the HCPCS codes that are payable under the MPFS as either a purchased test or interpretation for the calendar year. Effective for claims with dates of service on or after October 1, 2007, carriers/MACs must use the national abstract file to price all claims for purchased diagnostic interpretations, for all provider specialty types (including physicians), based on the ZIP code of the location where the service was rendered, in accordance with the carrier jurisdictional pricing rules specified in §10.1.1. (See IOM Publication 100-04, chapter 23, §30.6, and Addendum for record layouts and instructions for downloading the Abstract File for Purchased Diagnostic Tests/Interpretations.)

NOTE: As with all services payable under the MPFS, the ZIP code is used to determine the appropriate payment locality and corresponding fee for the purchased test/interpretation. When a ZIP code crosses county lines, CMS uses the dominant locality to determine the corresponding fee.

30.2.10 - Payment Under Reciprocal Billing Arrangements - Claims Submitted to Carriers

(Rev. 1486, Issued: 04-04-08, Effective: 01-01-08, Implementation: 05-05-08)

The patient's regular physician may submit the claim, and (if assignment is accepted) receive the Part B payment, for covered visit services (including emergency visits and related services) which the regular physician arranges to be provided by a substitute physician on an occasional reciprocal basis, if:

- The regular physician is unavailable to provide the visit services;
- The Medicare patient has arranged or seeks to receive the visit services from the regular physician;
- The substitute physician does not provide the visit services to Medicare patients over a continuous period of longer than 60 days subject to the exception noted below; and
- The regular physician identifies the services as substitute physician services meeting the requirements of this section by entering in item 24d of Form CMS-1500 HCPCS code Q5 modifier (service furnished by a substitute physician under a reciprocal billing arrangement) after the procedure code. When Form CMS-1500 is next revised, provision will be made to identify the substitute physician by entering the unique physician

identification number (UPIN) or NPI when required on the form and cross-referring the entry to the appropriate service line item(s) by number(s). Until further notice, the regular physician must keep on file a record of each service provided by the substitute physician, associated with the substitute physician's UPIN or NPI when required, and make this record available to the carrier upon request.

EXCEPTION: In accordance with section 116 of the "Medicare, Medicaid, and SCHIP Extension Act of 2007" (MMSE), enacted on December 29, 2007, the exception to the 60-day limit on substitute physician billing for physicians called to active duty in the Armed Forces has been extended for services furnished from January 1, 2008 through June 30, 2008. Thus, under this law, a physician called to active duty may bill for substitute physician services furnished from January 1, 2008 through June 30, 2008 for longer than the 60-day limit.

If the only substitution services a physician performs in connection with an operation are post-operative services furnished during the period covered by the global fee, these services need not be identified on the claim as substitution services.

A physician may have reciprocal arrangements with more than one physician. The arrangements need not be in writing.

The term "**covered visit service"** includes not only those services ordinarily characterized as a covered physician visit, but also any other covered items and services furnished by the substitute physician or by others as incident to the physician's services.

"Incident to" services furnished by staff of a substitute physician or regular physician are covered if furnished under the supervision of each.

A "**continuous period of covered visit services"** begins with the first day on which the substitute physician provides covered visit services to Medicare Part B patients of the regular physician, and ends with the last day the substitute physician provides services to these patients before the regular physician returns to work. This period continues without interruption on days on which no covered visit services are provided to patients on behalf of the regular physician or are furnished by some other substitute physician on behalf of the regular physician. A new period of covered visit services can begin after the regular physician has returned to work.

EXAMPLE: The regular physician goes on vacation on June 30, and returns to work on September 4. A substitute physician provides services to Medicare Part B patients of the regular physician on July 2, and at various times thereafter, including August 30 and September 2. The continuous period of covered visit services begins on July 2 and runs through September 2, a period of 63 days. Since the September 2 services are furnished after the expiration of 60 days of the period, the regular physician is not entitled to bill and receive direct payment for them. The substitute physician must bill for these services in his/her own name. The regular physician may, however, bill and receive payment for the services that the substitute physician provides on his/her behalf in the period July 2 through August 30.

The requirements for the submission of claims under reciprocal billing arrangements are the same for assigned and unassigned claims.

A. Physician Medical Group Claims Under Reciprocal Billing Arrangements

The requirements of this section generally do not apply to the substitution arrangements among physicians in the same medical group where claims are submitted in the name of the group. On claims submitted by the group, the group physician who actually performed the service must be identified in the manner described in §30.2.13 with one exception. When a group member provides services on behalf of another group member who is the designated attending physician for a hospice patient, the Q5 modifier may be used **by the designated attending physician** to bill for services related to a hospice patient's terminal illness that were performed by another group member.

For a medical group to submit assigned and unassigned claims for the covered visit services of a substitute physician who is **not** a member of the group and for an independent physician to submit assigned and unassigned claims for the substitution services of a physician who **is** a member of a medical group, the following requirements must be met:

- The regular physician is unavailable to provide the visit services;
- The Medicare patient has arranged or seeks to receive the visit services from the regular physician; and
- The substitute physician does not provide the visit services to Medicare patients over a continuous period of longer than 60 days.

Substitute billing services are billed for each entity as follows:

- The medical group must enter in item 24d of Form CMS-1500 the HCPCS code modifier Q5 after the procedure code.
- The independent physician must enter in item 24 of Form CMS-1500 HCPCS code modifier Q5 after the procedure code.
- The designated attending physician for a hospice patient (receiving services related to a terminal illness) bills the Q5 modifier in item 24 of Form CMS-1500 when another group member covers for the attending physician.
- A record of each service provided by the substitute physician must be kept on file and associated with the substitute physician's UPIN or NPI when required. This record must be made available to the carrier upon request.
- In addition, the medical group physician for whom the substitution services are furnished must be identified by his/her provider identification number (PIN) or NPI when required in block 24J of the appropriate line item.

Physicians who are members of a group but who bill in their own names are treated as independent physicians for purposes of applying the requirements of this section.

Carriers should inform physicians of the compliance requirements when billing for services of a substitute physician. The physician notification should state that, in entering the Q5 modifier, the

regular physician (or the medical group, where applicable) is certifying that the services are covered visit services furnished by the substitute physician identified in a record of the regular physician which is available for inspection, and are services for which the regular physician (or group) is entitled to submit the claim. Carriers should include in the notice that penalty for false certifications may be civil or criminal penalties for fraud. The physician's right to receive payment or to submit claims or accept any assignments may be revoked. The revocation procedures are set forth in §40.

If a line item includes the code Q5 certification, carriers assume that the claim meets the requirements of this section in the absence of evidence to the contrary. Carriers need not track the 60-day period or validate the billing arrangement on a prepayment basis, absent postpayment findings that indicate that the certifications by a particular physician may not be valid.
When carriers make Part B payment under this section, they determine the payment amount as though the regular physician provided the services. The identification of the substitute physician is primarily for purposes of providing an audit trail to verify that the services were furnished, not for purposes of the payment or the limiting charge. Also, notices of noncoverage are to be given in the name of the regular physician.

30.2.11 - Physician Payment Under Locum Tenens Arrangements - Claims Submitted to Carriers

(Rev. 1486, Issued: 04-04-08, Effective: 01-01-08, Implementation: 05-05-08)

A. Background

It is a longstanding and widespread practice for physicians to retain substitute physicians to take over their professional practices when the regular physicians are absent for reasons such as illness, pregnancy, vacation, or continuing medical education, and for the regular physician to bill and receive payment for the substitute physician's services as though he/she performed them. The substitute physician generally has no practice of his/her own and moves from area to area as needed. The regular physician generally pays the substitute physician a fixed amount per diem, with the substitute physician having the status of an independent contractor rather than of an employee. These substitute physicians are generally called "locum tenens" physicians.

Section 125(b) of the Social Security Act Amendments of 1994 makes this procedure available on a permanent basis. Thus, beginning January 1, 1995, a regular physician may bill for the services of a locum tenens physicians. A regular physician is the physician that is normally scheduled to see a patient. Thus, a regular physician may include physician specialists (such as a cardiologist, oncologist, urologist, etc.).

B. Payment Procedure

A patient's regular physician may submit the claim, and (if assignment is accepted) receive the Part B payment, for covered visit services (including emergency visits and related services) of a locum tenens physician who is not an employee of the regular physician and whose services for patients of the regular physician are not restricted to the regular physician's offices, if:

- The regular physician is unavailable to provide the visit services;

- The Medicare beneficiary has arranged or seeks to receive the visit services from the regular physician;

- The regular physician pays the locum tenens for his/her services on a per diem or similar fee-for-time basis;

- The substitute physician does not provide the visit services to Medicare patients over a continuous period of longer than 60 days subject to the exception noted below; and

- The regular physician identifies the services as substitute physician services meeting the requirements of this section by entering HCPCS code modifier Q6 (service furnished by a locum tenens physician) after the procedure code. When Form CMS-1500 is next revised, provision will be made to identify the substitute physician by entering his/her unique physician identification number (UPIN) or NPI when required to the carrier upon request.

EXCEPTION: In accordance with section 116 of the "Medicare, Medicaid, and SCHIP Extension Act of 2007" (MMSE), enacted on December 29, 2007, the exception to the 60-day limit on substitute physician billing for physicians called to active duty in the Armed Forces has been extended for services furnished from January 1, 2008 through June 30, 2008. Thus, under this law, a physician called to active duty may bill for substitute physician services from January 1, 2008 through June 30, 2008 for longer than the 60-day limit.

If the only substitution services a physician performs in connection with an operation are post-operative services furnished during the period covered by the global fee, these services need not be identified on the claim as substitution services.

The requirements for the submission of claims under reciprocal billing arrangements are the same for assigned and unassigned claims.

C. Medical Group Claims Under Locum Tenens Arrangements

For a medical group to submit assigned and unassigned claims for the services a locum tenens physician provides for patients of the regular physician who is a member of the group, the requirements of subsection B must be met. For purposes of these requirements, per diem or similar fee-for-time compensation which the group pays the locum tenens physician is considered paid by the regular physician. Also, a physician who has left the group and for whom the group has engaged a locum tenens physician as a temporary replacement may bill for the temporary physician for up to 60 days. The group must enter in item 24d of Form CMS-1500 the HCPCS modifier Q6 after the procedure code. Until further notice, the group must keep on file a record of each service provided by the substitute physician, associated with the substitute physician's UPIN or NPI when required, and make this record available to the carrier upon request. In addition, the medical group physician for whom the substitution services are furnished must be identified by his/her provider identification number (PIN) or NPI when required on block 24J of the appropriate line item.

Physicians who are members of a group but who bill in their own names are generally treated as independent physicians for purposes of applying the requirements of subsection A for payment for locum tenens physician services. Compensation paid by the group to the locum tenens physician is considered paid by the regular physician for purposes of those requirements. The term "regular physician" includes a physician who has left the group and for whom the group has hired the locum tenens physician as a replacement.

30.2.12 - Establishing That a Person or Entity Qualifies to Receive Payment on Basis of Reassignment - for Carrier Processed Claims

(Rev. 1, 10-01-03)

B3-3060.8

Any person or entity wishing to receive Part B payment as a reassignee of one or more physicians (or other practitioner or supplier), or as the supplier of the services, must furnish to the carrier sufficient information to establish clearly that it qualifies to receive payment for those services. Where there is any doubt that the person or entity qualifies, the carrier must obtain additional evidence.

In some cases, an entity may qualify to receive payment for the services of a physician on the basis of one or more of the exceptions listed in §30.2. As soon as it is determined that an organization can qualify on any basis, no further development may be needed for that physician or for other physicians having the same status. However, where some other physicians have or appear to have different status, further development is required. In some cases a determination is made that Part B payment can be made only to the physician.

Subject to the provisions of §§30, a reassignee assumes liability for any overpayments that it receives and should be so advised.

A. Payment to Special Accounts

Sometimes a major institution, such as a medical school or university, may want the Medicare checks due it for physician services to go into particular specialty accounts (or funds, or so-called group practices) which are subdivisions of the institution, and may ask that these accounts be identified on their Medicare checks for internal accounting purposes.

Ideally, to indicate the subordinate nature of the account in relation to the institution, carriers list the name of the institution first on the check, followed by the name of the appropriate account. However, identifying the payee in this manner may cause serious claims processing difficulties, fostering confusion between various accounts of the same institution. To avoid this problem, carriers may list the name of the account first, followed by the name of the institution, e.g., Radiology Fund or General Medical Center, if the institution submits a letter accepting responsibility for any claims submitted, and payments made, under the special designations. The letter needs to describe the special designations the institution wants on the checks for the various accounts and include a statement to the following effect:

> The (name of institution) accepts the same responsibility for the Medicare claims and payments made under these special designations as it would have if the payments were made by Medicare in the name of (name of institution) without these special designations.

This statement is required in addition to the statement the institution submits to establish its right to receive payment for the physicians' services.

If the above procedure is used as a basis for Part B payments in the names of departments, specialties, or similar subdivisions of a university or medical school or an associated nonprofit foundation or teaching hospital, each subdivision may also execute, or refrain from executing, a participation agreement for physician services in that subdivision. This is an exception to the rule that a participation agreement may only be executed by a person or legal entity. This exception applies only in the medical school or university medical center context.

30.2.13 - Billing Procedures for Entities Qualified to Receive Payment on Basis of Reassignment - for Carrier Processed Claims

(Rev. 1335, Issued: 09-14-07, Effective: 05-23-07, Implementation: 10-01-07)

Except where otherwise noted, the following procedures apply to both assigned and unassigned claims submitted by medical groups and other entities entitled to bill and receive payment for physician services under §§30.2-30.2.8. They are used whether the charges are compensation related or non-compensation related.

A General

Chapter 26 contains general claims processing instructions. A medical group, or other entity entitled to bill and receive payment for physician services uses Form CMS-1500 or the current ANSI X12N billing format to submit claims to Medicare carriers. A single claim form may contain services furnished to the same patient by different physicians associated with the same entity. The name and address of the entity is entered in block 33 of Form CMS-1500 or in the corresponding ANSI X12N location. For paper claims an authorized official of the entity signs in block 31. This official need not be a physician. For EDI claims a certification can be maintained on file. (See CMS EDI Web page (http://www.cms.hhs.gov/providers/edi/edi3.asp) for electronic billing formats.)

B Provider Identification Numbers

The entity's NPI, when required, is entered in block 33. Each physician who performs services for a patient must be identified on Form CMS-1500 in block 24J for the appropriate line item in accordance with instructions in the Medicare Program Integrity Manual. (When an entity bills for an independent substitute physician under a reciprocal or locum tenens billing arrangement, the performing physicians is the physician member of the entity for whom the substitute is providing services.)

C Payment Records

Where the charges by a hospital, medical group, or other entity differ depending on the individual treating physician, carriers transmit the performing physician's UPIN or NPI when required on the Common Working File (CWF) claim record. Where the charges by a hospital, medical group, or other entity are uniform regardless of the individual performing physician, claims records are prepared by entity and entity identification numbers rather than by individual physician and individual physician identification numbers. Show code 70 as specialty code on

claims records where such entity's physicians have mixed (more than one) specialties. Where all the physicians associated with such entity have the same specialty, the code used reflects the specialty, e.g., code 30 for a group of radiologists, code 11 for a group of internists.

D Outpatient Physical Therapy or Speech-Language Pathology Claims

Clinics that have been certified to provide outpatient physical therapy or speech-language pathology services to outpatients also use Form CMS-1500 for billing the Part B carrier.

30.2.14 - Correcting Unacceptable Payment Arrangements

(Rev. 1, 10-01-03)

A3-3488.3, B3-3060.6.E, B3-3060.12

A. Disseminating Information

From time to time, carriers and FIs must disseminate through professional relations media information regarding the prohibition in §30.2.

FIs

The following language may be used by FIs or adapted for this purpose:

The Medicare law prohibits us from paying benefits due a provider to another person or organization under an assignment, power of attorney, or any other arrangement whereby that other person or organization receives those payments directly. There are the following exceptions to this rule:

- CMS may pay a provider's benefits (in the provider's name) to a billing or collection agent, if:
    - The agent receives the payment under an agency agreement with the provider;
    - The agent's compensation is not related in any way to the dollar amounts billed or collected;
    - The agent's compensation is not dependent upon the actual collection of payment;
    - The agent acts under instructions which the provider may modify or revoke at any time; and
    - The agent, in receiving payment, acts only in the providers' behalf.
- CMS may pay the providers' benefits in accordance with an assignment established by, or pursuant to the order of, a court of competent jurisdiction.

A provider should notify us immediately if:

- CMS has been mailing its benefits to the address of another person or organization;
- The provider has given that other person or organization power of attorney or other advance authority to negotiate its benefit checks; and

- None of the above exceptions that would permit payment to another person or organization apply in the provider's case.

A provider which hereafter enters into or continues such a prohibited payment arrangement may have its participation in the program terminated and its right to receive assigned payment for physician services revoked.

Carriers/DMERCS

A carrier/DMERC may use or adapt the following language for notification:

The Medicare law prohibits us from paying benefits due a physician or other supplier of health care items and services, to another person or organization, under a reassignment or power of attorney or under any other arrangement whereby that other person or organization receives those payments directly. There are the following exceptions to this rule:

- CMS may pay a physician's or supplier's employer under the terms of his/her employment.
- CMS may pay a hospital, clinic, or other facility for services furnished by the physician or supplier in the facility, in accordance with the physician's or supplier's agreement with the facility.
- CMS may pay a group practice prepayment plan, prepaid health plan, or HMO for services of physicians and suppliers associated with the plan.
- CMS may pay a physician or medical group for purchased diagnostic tests (other than clinical diagnostic tests).
- CMS may pay a supplier of diagnostic tests for interpretations purchased from a physician or medical group that did not initiate the tests.
- CMS may pay the patient's regular physician for services provided to his/her patients by another physician on an occasional, reciprocal basis
- At least until December 31, 1993, CMS may pay the patient's regular physician for services of a locum tenens physician during the absence of the regular physician where the regular physician pays the locum tenens on a per diem or similar fee-for-time basis.
- CMS may pay a physician's or supplier's benefits in his/her name to a billing or collection agent, e.g., a medical bureau, if:
    - The agent receives the payment under an agency agreement with the physician or supplier;
    - The agent's compensation is not related in any way to the dollar amounts billed or collected;
    - The agent's compensation is not dependent upon the actual collection of payment;
    - The agent acts under instructions which the physician or supplier may modify or revoke at any time; and
    - The agent, in receiving the payment, acts only on the physician's or supplier's behalf.

- CMS may pay a physician's or supplier's benefits in accordance with a reassignment established by, or pursuant to the order of, a court of competent jurisdiction.

A physician or supplier should notify us immediately if:

- CMS has been mailing his/her benefits to the address of another person or organization;
- The physician has given that other person or organization power of attorney or other advance authority to negotiate the physician's benefit checks; and
- None of the above exceptions which would permit payment to another person or organization apply in his/her case.

A physician or other eligible recipient of assigned payment who hereafter enters into or continues such a prohibited payment arrangement may have the right to receive assigned payment revoked.

30.2.14.1 - Questionable Payment Arrangements

(Rev. 1, 10-01-03)

A. Developing Questionable Payment Arrangements

Contractors (both FIs and Carriers) should assume that an arrangement in which Medicare payment is being sent or is to be sent to an address other than the physical location of the provider/supplier is consistent with the requirements of §30.2 in the absence of evidence to the contrary. However, develop the facts of any case in which:

- The contractor becomes aware that it is mailing or asked to mail the provider/supplier's payments to the address of another person or organization; **and**
- It is likely the other person or organization is not qualified to receive payments under one of the exceptions in §30.2.1 or is a financial institution. (See §30.2.5.)

Contractors must develop the facts of the case, e.g., where it appears that the contractor is mailing or asked to mail the provider provider/supplier's payments to the address of a company known to be engaging in factoring.

B. How to Develop Questionable Payment Arrangements

Discretion must be used in determining the procedure to follow in developing questionable payment arrangements. Contractors should ascertain the reason for the special address. Once it is determined that payments due the provider/supplier are being made to another party (although in the name of the provider), the contractor must ascertain whether any of the exceptions in §30.2.1 apply. After initial contact with the provider/supplier, the contractor may find the other party to be the best source of information about the arrangement. The contractor should establish the crucial elements of the arrangement by obtaining a copy of the formal agreement, if any, between the parties, copies of pertinent correspondence, and/or signed statements of the parties. The failure of the provider/supplier to cooperate in furnishing the necessary information (or in giving any necessary authorization for others to furnish information) is grounds (see §30.2.15) for terminating the provider/supplier's participation in the program and revoking its right to receive assigned payment.

C. Change of Address

If the contractor determines that a person or organization is ineligible to receive payments due a provider/supplier, routinely mailing the provider/supplier's payments to that person or organization's address should be discontinued. However, such a mailing address is acceptable if:

- The parties to the arrangement have given written assurances that the person or organization to whose address the check is mailed will not convert the check to its own use and control, or if the organization is a financial institution, that the requirements of §30.2.5 are met; and
- The purpose of the arrangement makes the assurances credible.

An acceptable mailing arrangement could exist, e.g., when the provider/supplier wants its checks mailed for bookkeeping purposes to a business agent who is ineligible to receive the payment, and both the agent and the provider state in writing that the agent will forward the checks to the provider's bank for deposit in a business account from which the provider/supplier is free to withdraw any deposited funds.

D. Reviewing Endorsements on Checks

In any case where the contractor, after developing the facts, continues to mail the provider's payments to an address which may be that of another person, but still doubts that the arrangement is inconsistent with these instructions, review (after a reasonable interval) endorsements on the returned checks for indications that the checks are being negotiated under a power of attorney. When someone negotiates a provider/supplier's checks under a power of attorney, the provider/supplier's name is typically printed on the back of the check with the endorsee's signature below, followed by "p.p." or "p.p.a." or "p.o.a" (for per procuration, per power of attorney, or power of attorney).

30.2.15 - Sanctions for Prohibited Payment Arrangement

(Rev. 1, 10-01-03)

A3-3488.4, B3-3060.13, B3-3060.14

A. Advice to Provider

If the contractor finds that a provider (for Part B, physician or other supplier, or party eligible to receive the payment under §30.2 as an employer, facility or organization) has entered into, or is considering entering into, a payment arrangement prohibited by §30.2, the contractor must advise that provider in writing that the arrangement violates Medicare law and regulations and subjects the provider to the penalties described in subsections B and C. When the improper payment arrangement is in effect, the contractor must require a change in the address to which the provider's checks are sent. For an exception, see §30.2.14.1C.

B. Bases for Termination of a Provider's Medicare Participation Agreement

The CMS may terminate a provider's Medicare participation agreement if the provider/physician:

- Executes or continues an assignment or a power of attorney, or enters into or continues any other arrangement, that authorizes or permits Medicare cost-basis payments to be made contrary to §§30.2, 42 CFR 405.1668, and §1815(c) of the Act after having been advised under subsection A above; or
- Fails to furnish upon request by CMS or the contractor such information as CMS or the contractor finds necessary to establish compliance with the requirements of this section.

The provider has the usual appeal rights applicable to agreement termination determinations.

C. Bases for Revocation of Assignment Privilege

The CMS may revoke the right of a provider to receive assigned payment for physician services if the provider:

- Executes or continues a reassignment or power of attorney, or enters into or continues any other arrangement, that authorizes or permits Medicare charge basis payments to be made contrary to §§30.2, 42 CFR 405.1680, and §1842(b)(6) of the Act, after CMS or the carrier gives the provider advice about such violation;
- Fails to furnish upon request by CMS or the carrier evidence needed to establish compliance with the requirements of §§30.2, 42 CFR 405.1680, and §1842(b)(6) of the Act;
- Violates the terms of assigned payment; e.g., by collecting or attempting to collect more than the allowable amount, after CMS or the carrier gives the provider advice about such violations; or
- Fails to desist from collection efforts already begun, or to refund monies incorrectly collected, in violation of the terms of assigned payment, after CMS or the carrier gives the provider instructions to cease to take such action.

A special appeals procedure is provided within CMS when action is taken to revoke a provider's right to accept assignment.

The fact that a provider's right to accept assignment is revoked does not preclude it from billing the beneficiary for the services or changing its arrangement with the physician to permit billing for rendered services, either on an assigned or unassigned basis. On the other hand, a provider is not ordinarily precluded from accepting assignment from a beneficiary for the services of a physician whose assignment privilege has been revoked if the beneficiary has an agreement with the provider giving it the right to bill for services rendered. There is an exception. The revocation of a physician's assignment privilege automatically revokes the assignment privilege of any corporation, partnership, or other entity in which the provider/supplier directly or indirectly has or obtains all or all but a nominal part of the financial interest. Such entity may not accept assignment for the services of the physician or anyone else. What is a nominal interest depends upon the circumstances. The contractor may assume that an interest by other persons totaling at least five percent of the financial interest of the entity is more than nominal. The term "indirect interest" refers to the situation where the entity billing for the physician's services is owned by another entity in which the physician has most of the financial interest.

D. Action When Violations Are Found

When the contractor finds that the provider/supplier has, after warning to the contrary, entered into, or continued, a prohibited payment arrangement, failed to cooperate in furnishing the information necessary to resolve the issue, violated its assignment agreement or failed to correct a violation of its assignment agreement, the contractor forwards a copy of the file to the program integrity staff in the RO. The RO considers whether further development of the facts or admonition of the provider will be useful before taking steps to terminate its participation agreement and/or to revoke its right to accept assignment.

In imposing the administrative sanction of revocation of the assignment privilege, the RO notifies the provider/supplier of the proposed revocation of its right to receive assigned benefits

and gives it 15 days in which to submit a statement, including any pertinent evidence, explaining why its right to payment should not be revoked. After the statement has been submitted, or the 15-day period has expired without the filing of the statement, the RO determines whether to revoke the provider/supplier's right to receive assigned payment. If its determination is to revoke, the RO notifies the contractor to suspend payment on all assigned claims submitted by the provider/supplier and received after the effective date of the revocation. It notifies the provider/supplier of the revocation and of its right to request a hearing on the revocation within 60 days. (The RO may extend the period for requesting a hearing.)

If the provider/supplier requests a formal hearing (to be conducted by a member of the hearings staff of CMS) and the hearing officer reverses the revocation determination, the RO instructs the carrier and FI to pay the provider/supplier 's assigned claims (the physician component). If the hearing officer upholds the revocation determination or if no request for a hearing is filed during the period allowed for this, the RO instructs the carrier and FI to make any assigned payments otherwise due the provider to the beneficiary who received the services, or another person or agency authorized under the law and regulations to receive the payments (e.g., the beneficiary's legal guardian or representative payee or, if the beneficiary is deceased, the person who paid the bill). The revocation remains in effect until the RO finds that the reason for the revocation has been removed and that there is reasonable assurance that it will not recur. The RO decision to continue the revocation in effect may not be appealed.

The law provides that any person who accepts assignment of benefits under Medicare and who "knowingly, willfully, and repeatedly" violates the assignment agreement shall be guilty of a misdemeanor and subject to a fine of not more than $2000 or imprisonment of not more than six months or both. The RO may invoke the administrative sanction in appropriate cases to deny payment while criminal prosecution is being considered or in process, or, as an alternative, when prosecution is inappropriate or not feasible. Since this sanction may in some cases interfere with effective prosecution, imposition of the sanction is discretionary rather than mandatory.

30.2.16 - Prohibition of Assignments by Beneficiaries

A3-3488.5, B3-3060.15, B3-7065 partial

A. Basic Prohibition

Except as provided in subsection B, carriers pay only the beneficiary (or beneficiary legal representative or representative payee) benefits payable directly to the beneficiary FIs do not send money directly to beneficiaries, they must require providers they pay to refund monies to beneficiaries when circumstances so warrant (i.e., when a provider has collected money from a beneficiary for a demand-billed service that is later found to be covered by Medicare). This prohibition does not, of course, apply to payment under an assignment of benefits by the beneficiary to the physician or other supplier who furnished the services or to a qualified reassignee, e.g., a hospital.

B. Exceptions

- Payment to a Government Agency. The law does not preclude the Medicare program from paying the benefits due a beneficiary to a governmental agency or entity. However, see §30.2.1 for the effect of the requirements of the Assignment of Claims Act.
- Payment Pursuant to Court Order. The Medicare program may make payment of amounts due a beneficiary, in accordance with an assignment established by, or pursuant

to the order of, a court of competent jurisdiction. The assignment must satisfy the conditions in §§30.2.

- Payment to Agent. The Medicare program may make payment in the name of the provider to an agent who furnishes billing or collection services. The payment arrangement between the provider and an agent must meet the same requirements as the payment arrangement between a physician and an agent. (See §30.2.4 for payment to an agent of a physician.)
- Indirect Payment. A carrier may make payment of amounts due a beneficiary to an entity which:

    - Provides coverage of the service under a health benefits plan but only to the extent that payment is not made under Part B (i.e., the coverage which the plan provides is complementary to Medicare and covers only the amount by which the Part B payment falls short of the charge approved under the plan for the service);

    - Pays the person who provided the service (or his/her reassignee under §§30.2.6 - 30.2.8) an amount (including the Part B benefit) which that person accepts as full payment; or

    - Has the written authorization of the beneficiary (or beneficiary representative) to receive the Part B payment.

30.3 - Physician/Practitioner/Supplier Participation Agreement and Assignment - Carrier Claims

(Rev. 1035, Issued: 08-18-06, Effective: 07-01-06, Implementation: 09-18-06)

Institutional providers (those that bill Fiscal Intermediaries (FIs)) are paid direct by the FI. In contrast, physicians, practitioners, and suppliers that bill the carrier may choose to enter into a participation agreement.

Carrier "Participating Providers" are paid at 100 percent of the physician fee schedule and must accept assignment (must accept program payment as payment in full, except for any unmet deductible and coinsurance). "Non-participating providers" are paid at 95 percent of the physician fee schedule and may accept assignment on a claim-by-claim basis.

Physicians and suppliers enrolled in the Medicare program under the Form CMS-855 process do not have to sign a "Medicare Participating Physician or Supplier Agreement" in order to bill Medicare and receive payment. However, there is a 5 percent reduction in the Medicare approved amounts if the physician or his/her reassignee does not participate. Participation is an election that is optional to suppliers, even those that have to bill assigned.

Also, regardless of participation, some suppliers and practitioner types are required to accept assignment. This is covered in the instructions in later chapters for each service type.

30.3.1 - Mandatory Assignment on Carrier Claims

(Rev. 1325; Issued: 08-29-07; Effective: 01-01-08; Implementation: 01-07-08)

The following practitioners who provide services under the Medicare program are required to accept assignment for all Medicare claims for their services. This means that they must accept

the Medicare allowed amount as payment in full for their practitioner services. The beneficiary's liability is limited to any applicable deductible plus the 20 percent coinsurance.

Assignment is mandated for the following claims:

- Clinical diagnostic laboratory services and physician lab services;
- Physician services to individuals dually entitled to Medicare and Medicaid;

Services of physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives, certified registered nurse anesthetists, clinical psychologists, clinical social workers, registered dietitians/nutritionists, anesthesiologist assistants, and mass immunization roster billers.

NOTE: The provider type Mass Immunization Roster Biller can only bill for influenza and pneumococcal vaccinations and administrations. These services are **not** subject to the deductible or the 20 percent coinsurance.

- Ambulatory surgical center services; (No deductible and 25% coinsurance for colorectal cancer screening colonoscopies {G0105 and G0121) and effective for dates of service on or after January 1, 2008 G0104 also applies);

- Home dialysis supplies and equipment paid under Method II;

- Drugs and biologicals; and,

- Ambulance services

When these claims are inadvertently submitted as unassigned, carriers process them as assigned.

Note that, unlike physicians, practitioners, or suppliers bound by a participation agreement, practitioners/entities providing the services/supplies identified above are required to accept assignment only with respect to these services/supplies (unless they have signed participation agreements which blanket the full range of their services).

The carrier system must be able to identify (and update) the codes for those services subject to the assignment mandate.

For the practitioner services of physicians and independently practicing physical and occupational therapists, the acceptance of assignment is not mandatory. Nor is the acceptance of assignment mandatory for the suppliers of radiology services or diagnostic tests. However, these practitioners and suppliers may nevertheless voluntarily agree to participate to take advantage of the higher payment rate, in which case the participation status makes assignment mandatory for the term of the agreement. Such an agreement is known as the Medicare Participating Physician or Supplier Agreement. (See §30.3.12.2 Carrier Participation Agreement.) Physicians, practitioners, and suppliers who sign this agreement to participate are agreeing to accept assignment on all Medicare claims. The Medicare Participation Agreement and general instructions are on the CMS Web site.

Future updates to this section will be communicated in a Recurring Update Notification.

30.3.1.1 - Processing Claims for Services of Participating Physicians or Suppliers by Carriers

(Rev. 1, 10-01-03)

B3-3040.3

The participating physician or supplier submits any claims for services furnished by the physician or supplier, except in the limited circumstances specified in §30.2.8.3 or §30.2.16. (The exception concerns situations where the physician or supplier accepts, as full payment, payment by certain organizations.) When an unassigned claim is received from a physician, the carrier must verify that the physician is participating. The carrier processes the claim as assigned absent clear evidence of intent by the physician or beneficiary not to assign. The following message must be printed on the remittance advice:

> We believe you inadvertently submitted this claim as unassigned. As a participating physician, you agree to accept assignment on all claims. We are, therefore, processing this claim as assigned.

Any Form CMS-1500 claim where the participating physician or supplier checks either the assignment or non-assignment block or fails to check either block, the carrier must treat it as assigned.

Where there is evidence of clear intent not to assign, the carrier must deny the claim. Use MSN 16.6

> "This item or service cannot be paid unless the provider accepts assignment.

In Spanish:

> "Este artículo o servicio no se pagará a menos de que el proveedor acepte asignación."

Carriers must identify and track assignment violations in the event sanctions must be imposed.

No Part B payment is made on a claim by a participating physician or supplier to anyone other than the physician or supplier (except in the case of court-ordered assignment to other parties under §30.2) even if the beneficiary has paid part of the bill. However, if the physician or supplier collects any charges from the beneficiary before submitting the claim, he/she must show on the claim form the amount collected. The carrier refunds directly to the beneficiary, to the extent feasible, any over collection of deductible and coinsurance. The physician is responsible for refunding to the beneficiary any over collection not refunded by the carrier directly. In these latter instances, the carrier advises the physician of his/her obligation to refund any over collections to the beneficiary. Also, the carrier advises the beneficiary of the amount of any refund due from the physician.

30.3.2 - Nature and Effect of Assignment on Carrier Claims

(Rev. 643, Issued: 08-12-05, Effective: 01-01-05, Implementation: 11-14-05)

Assignment is a written agreement between beneficiaries, their physicians or other suppliers, and Medicare. The beneficiary agrees to let the physician or other supplier request direct payment from Medicare for covered Part B services, equipment, and supplies by assigning the claim to the physician or supplier. The physician/supplier in return agrees to accept the Medicare allowed payment amount by the carrier as his/her full charge for the items or services. A physician/supplier who agrees to accept assignment on all claims for Medicare services, rather

than on a claim-by-claim basis is known as a participating physician/supplier. See Publication 100-4, chapter 1, sections 30.3 and 30.3.12.2 of the IOM. In effect, the physician/supplier who accepts assignment on a claim-by-claim basis or who is a participating physician/supplier is precluded from charging the enrollee more than the deductible and coinsurance based upon the approved payment amount determination. If dissatisfied with the amount of the Medicare allowed amount, a physician/supplier may follow the procedures for appeals of contractor initial determinations.

In "mandatory assignment" situations, i.e., where payment under the Act can be made only on an assignment-related basis or where payment is for services furnished by a participating physician or supplier, the beneficiary (or the person authorized to request payment on the beneficiary's behalf) is not required to assign the claim to the physician or supplier in order for an assignment to be effective. However, the beneficiary (or the person authorized to request payment on the beneficiary's behalf) must continue to authorize the release of medical or other information necessary to process the claim and request payment of Medicare benefits for the Medicare Part B covered services, equipment, or supplies pursuant to 42 C.F.R 424.32 and 424.36 (see also Pub. 100-04, ch. 1, sect. 50.1). Physicians or suppliers who agree to (or must by law) accept assignment from Medicare cannot attempt to collect more than the appropriate Medicare deductible and coinsurance amounts from the beneficiary, his/her other insurance, or anyone else.

In situations where mandatory assignment is not applicable and a nonparticipating physician or supplier indicates on the claim that he/she accepts assignment, but the beneficiary does not assign the claim to that nonparticipating physician/supplier-- payment must be made on an unassigned basis (i.e., directly to the beneficiary).

A violation of the assignment occurs if the physician/supplier collects (or attempts to collect) from the enrollee or anyone else any amount which, when added to the benefit, exceeds the Medicare allowed amount. A bill for assigned services is considered paid in full when the Medicare allowed amount is paid. The carrier payment determination takes into account all of the services furnished by the physician/supplier in connection with the claim. Therefore, a physician/supplier may not charge the enrollee for paperwork involved in filing an assigned claim.

If the enrollee has private insurance in addition to Medicare, the physician/supplier who has accepted assignment of SMI benefits is in violation of his/her assignment agreement if he/she bills or collects from the enrollee and/or the private insurer an amount which, when added to the Medicare benefit received, exceeds the Medicare allowed amount. If it comes to a carrier's attention that a physician/supplier has received an excessive amount, inform him/her to refund such amount to the appropriate party. Where it is not clear as to who is entitled to receive the refund under the terms of the private insurance, any excess amount paid by the enrollee may be returned to the enrollee.

A nonparticipating physician/supplier who accepts assignment for some Medicare covered services is not ordinarily precluded from billing the patient for other Medicare covered services for which the nonparticipating physician/supplier does not accept assignment, and is also not precluded from billing the patient for services that are not covered by Medicare. However, a physician/supplier may not attempt to circumvent the Medicare allowed amount limitation by "fragmenting" his/her bills. Bills are "fragmented" when a physician/supplier accepts assignment for some services, and claims payment from the enrollee for other services performed at the same place and on the same occasion. When a carrier becomes aware that a

physician/supplier is fragmenting his/her bills, it must inform him/her that this practice is unacceptable and that he/she must either accept assignment for, or bill the enrollee for, all services performed at the same place and on the same occasion.

EXCEPTION: In mandatory assignment situations, i.e., where a physician/supplier must accept assignment for certain services as a condition for any payment or for full payment to be made (e.g., clinical diagnostic laboratory tests, physician assistants), he/she may accept assignment for those services without accepting assignment for other services furnished by him/her for the same enrollee at the same place and on the same occasion.

30.3.3 - Physician's Right to Collect From Enrollee on Assigned Claim Submitted to Carriers

(Rev. 1, 10-01-03)

B3-3045.2

A. Before the Claim is Submitted

The provider (including physicians and suppliers) who is accepting assignment should not attempt to collect more than 20 percent of the charge from the enrollee when the deductible has been met. He or she should, if the occasion arises, be advised not to do so. Any greater amount collected will:

1. Reduce the amount payable to him/her on the assigned claim,
2. Cause the enrollee unnecessary hardship in raising the excess amount, and
3. Require extra work for the carrier in paying this excess to the enrollee instead of the physician.

However, a provider (including physicians and suppliers) may accept assignment after having collected a part of his/her bill. The fact that the enrollee has paid more than any deductible and coinsurance due does not invalidate the assignment.

B. Showing the Amount Collected on the Claims Form

In submitting an assigned claim, the provider (including physicians and suppliers) must show on Form CMS-1500 any amount he/she has collected from the enrollee for these services. This information is essential for correct payment of the benefits due; failure to show the amount paid is likely to result in excessive benefit payment to the provider (including physicians and suppliers) (i.e., a benefit payment which, when added to the amount already paid by the enrollee, will exceed the Medicare allowed amount).

EXAMPLE: The physician accepted assignment of a bill of $300 for covered services and collected $60 from the enrollee, but failed to show on the claim form that he/she had collected anything. The carrier determined the Medicare allowed amount to be $250, and since the deductible had previously been met, made payment of $200 to the physician. Since the physician would have received $190 in benefit payments and the enrollee $10 if the amount collected had been shown on the claim form, the physician has been overpaid $10. When this overpayment comes to light, e.g., by a complaint from the enrollee, the carrier will take necessary corrective action, e.g., advise the physician to refund the $10 to the enrollee and if he/she fails to do so, pay the enrollee the $10 and recover the overpayment from the physician.

C. Physician Should Not Bill Enrollee After the Claim is Submitted

After the provider (including physicians and suppliers) has accepted assignment he/she should not bill the enrollee or try to collect from him/her any additional part of the bill until he/she receives the carrier's Medicare Summary Notice (MSN). Where the provider (including physicians and suppliers) collects any substantial part of his/her bill from the enrollee **after** submitting his/her claim, such collection is likely to be an overcollection, and a violation of the assignment agreement. Furthermore, the enrollee who receives a bill from the provider (including physicians and suppliers) may submit such bill to the carrier with his/her own claim for benefits, causing confusion, possible duplicate payment, or payment of benefits to the enrollee rather than the provider (including physicians and suppliers).

EXAMPLE: The physician accepted assignment of a bill of $300 for covered services, and collected $60 from the enrollee after the Form CMS-1500 had been filed with the carrier, but before receiving notice of the Medicare allowed amount. The carrier determined that the Medicare allowed amount was $250, and since the Form CMS-1500 did not show any payment made by the enrollee, paid the physician $200 (80 percent of the $250 Medicare allowed amount). The result is that the physician has overcollected from the enrollee by $10.

When this overcollection came to light through a complaint from the enrollee, the carrier notified the physician that the $10 must be refunded to the enrollee. Unlike the excess payment made because the physician fails to show the amount collected on the claims form (see the example in B above), this $10 does not constitute a program overpayment; the carrier should not apply recovery procedures applicable to overpayments, and should not pay the $10 to the patient unless the physician first "refunds" it to the carrier (in lieu of refunding it directly to the patient).

If the physician, **after submitting his/her claim**, collects an additional amount on his/her bill, and the carrier learns of such collection before making SMI payment, the carrier should adjust its payments to the physician and enrollee accordingly. However, even if the physician collected the entire bill, requiring that the full SMI benefit be paid to the enrollee, the Medicare allowed amount limitations of the assignment still apply.

D. Durable Medical Equipment Supplier Bills for Coinsurance at the Time Claim Submitted

Notwithstanding the guideline in C above, a supplier of durable medical equipment may bill the beneficiary for 20 percent of the Medicare allowed amount at the same time it submits an assigned claim to the carrier for the items and services furnished. The supplier must undertake:

1. To bill the beneficiary at the time it submits the claim only for 20 percent of the Medicare allowed amount; and
2. To inform the beneficiary prominently on its invoice that:
    a. It has submitted a claim to the carrier for the items and services and he/she should not him/her self submit such a claim; and
    b. The bill is for 20 percent of the Medicare allowable charge and is not covered by Medicare; and
3. To establish and maintain adequate procedures for refund of any over collections from the beneficiary that might result from the carrier approving a different Medicare allowed amount than that submitted.

30.3.4 - Effect of Assignment Upon Rental or Purchase of Durable Medical Equipment on Claims Submitted to Carriers

(Rev. 1, 10-01-03)

B3-3045.3

A. Equipment More Expensive Than Standard Item

An item of durable medical equipment may have certain convenience or luxury features that make it more expensive than a standard item, i.e., one which will adequately meet the medical needs of the patient. The charge for the more expensive item cannot exceed the fee schedule amount for the item adequate for the patient's medical needs. Only if a more expensive item or model with special features is medically necessary for the beneficiary will the Medicare allowed amount be based on the more expensive model. If the patient purchases or rents an item of durable medical equipment having more expensive features than his/her condition requires, the supplier accepting assignment on such an item cannot charge or collect any amount in excess of the Medicare allowed amount for the appliance adequate for the patient's needs. Acceptance of assignment binds the supplier to accept the Medicare allowed amount determined by the carrier, as the full charge for the item. A supplier who wishes to charge and collect the full price for equipment more expensive than medically required by the patient need not accept assignment.

Refer to chapter 30, for advance beneficiary notice (ABN) provisions.

EXAMPLE: An enrollee who needs a wheelchair is sold a motorized chair although a manually operated chair would meet his/her medical needs. The Medicare allowed amount in this case is the Medicare allowed amount for a manually operated chair. Therefore, if the supplier accepts assignment, he/she cannot collect from the enrollee any amount in excess of the difference between the amounts of the SMI benefit paid to the supplier and the Medicare allowed amount for the manually-operated chair.

B. Equipment No Longer Medically Necessary

In assignment cases, the beneficiary is responsible for paying the supplier the unpaid balance of the Medicare allowed amount when payments stop because his/her condition has changed and the equipment is no longer medically necessary. Similarly, when payments stop because the beneficiary dies, his/her estate is responsible to the supplier for such unpaid balance.

NOTE: Carriers should not get involved in issues relating to ownership or title to property.

30.3.5 - Effect of Assignment Upon Purchase of Cataract Glasses From Participating Physician or Supplier on Claims Submitted to Carriers

(Rev. 1, 10-01-03)

B3-3045.4

A pair of cataract glasses is comprised of two distinct products: a professional product (the prescribed lenses) and a retail commercial product (the frames). The frames serve not only as a holder of lenses but also as an article of personal apparel. As such, they are usually selected on the basis of personal taste and style. Although Medicare will pay only for standard frames, most patients want deluxe frames. Participating physicians and suppliers cannot profitably furnish such deluxe frames unless they can make an extra (noncovered) charge for the frames even though they accept assignment.

Therefore, a participating physician or supplier (whether an ophthalmologist, optometrist, or optician) who accepts assignment on cataract glasses with deluxe frames may charge the Medicare patient the difference between his/her usual charge to private pay patients for glasses

with standard frames and his/her usual charge to such patients for glasses with deluxe frames, in addition to the applicable deductible and coinsurance on glasses with standard frames, if all of the following requirements are met:

A. The participating physician or supplier has standard frames available, offers them for sale to the patient, and issues and ABN to the patient that explains the price and other differences between standard and deluxe frames. Refer to Chapter 30.

B. The participating physician or supplier obtains from the patient (or his/her representative) and keeps on file the following signed and dated statement:

_____

Name of Patient Medicare Claim Number

Having been informed that an extra charge is being made by the physician or supplier for deluxe frames, that this extra charge is not covered by Medicare, and that standard frames are available for purchase from the physician or supplier at no extra charge, I have chosen to purchase deluxe frames.

_____

Signature Date

C. The participating physician or supplier itemizes on his/her claim his/her actual charge for the lenses, his/her actual charge for the standard frames, and his/her actual extra charge for the deluxe frames (charge differential).

Once the assigned claim for deluxe frames has been processed, the carrier will follow the ABN instructions as described in §60.

30.3.6 - Mandatory Assignment Requirement for Physician Office Laboratories on Claims Submitted to Carriers

(Rev. 1, 10-01-03)

B3-3045.5

A. General

No payment may be made for clinical diagnostic laboratory tests furnished by a physician or medical group unless the physician or medical group accepts assignment or claims payment under the indirect payment procedure. Carrier direct payment to a physician or group after the death of the beneficiary is considered assigned payment. Assignment may be accepted for the entire claim. See subsections B and C if a physician wishes to accept assignment only for laboratory services.

B. Submission of Non-EMC Claims

A nonparticipating physician or medical group who furnishes clinical diagnostic laboratory tests and other services to a beneficiary and accepts assignment only for the laboratory tests may either submit a separate (assigned) claim for them or a single claim that includes both the assigned tests and the other unassigned services. In the latter event, the claim must be annotated as unassigned in block 26 of the Form CMS-1500 and a special request for payment for the assigned tests written in block 25, as follows:

"I accept assignment for the clinical laboratory tests."

C. Submission of EMC Claims

A nonparticipating EMC physician or medical group who furnishes clinical diagnostic laboratory tests and other services and accepts assignment only for the laboratory tests may either submit a separate (assigned) data set for the tests or a single data set that includes both the assigned tests and the unassigned other services. In the latter event, the data set must include the unassigned indicator. The physician or group must have filed a blanket statement agreeing to accept assignment on all clinical diagnostic laboratory tests, not withstanding the inclusion of the unassigned indicator on electronic data sets.

D. Processing Claims

Carriers process as assigned all claims for clinical diagnostic laboratory tests as described above, including those submitted by a participating or non-participating physician or group either marked as unassigned or with no assignment option specified. Where, however, evidence clearly shows that the beneficiary or provider refuses to assign the claim, carriers should deny it. They split a claim containing assigned laboratory tests and other unassigned services.

E. Public Information

Carriers must inform all physicians and medical groups of this policy annually.

30.3.7 - Physicians Billing for Purchased Diagnostic Tests (Other Than Clinical Diagnostic Laboratory Tests) on Claims Submitted to Carriers

(Rev. 1, 10-01-03)

B3-3045.6

A. General

Effective April 1, 1988, a physician may not mark up purchased diagnostic tests. If a physician's bill or a request for payment includes a charge for a diagnostic test (other than a clinical diagnostic laboratory test) which the physician did not personally perform or supervise, payment for the test may not exceed the lesser of:

- The actual acquisition cost (net any discounts); or
- The lower of the supplier's Medicare allowed amount for the test.

For payment to be made, the physician who purchases a test from an outside source must identify the supplier, the supplier's provider number and the amount the supplier charged. No payment may be made to the physician without this information unless the statement "No purchased tests are included" is annotated on the claim.

B. Unassigned Claims with Required Documentation

A physician may not bill an individual an amount in excess of Medicare's payment, except for any deductible and coinsurance, for a purchased diagnostic test. Carriers must notify physicians to indicate when a diagnostic test was purchased, identify the supplier, and show the amount the supplier charged. The notification must inform physicians that they are prohibited by §1842(n)(3) of the Act from billing or collecting an amount in excess of Medicare's payment, except for the deductible and coinsurance. Excess amounts collected from the beneficiary must be repaid.

C. Unassigned Claims without Required Documentation

A physician may not bill a beneficiary:

- If the bill does not indicate who performed the test; and
- If the bill indicates that a supplier performed the test, it does not identify the supplier or does not include the amount it charged.

Carriers notify the physician when a non-assigned claim for purchased services is received from either the physician or a beneficiary except when the physician submits an assigned claim and the beneficiary submits an unassigned duplicate claim. They use the following sample letter.

> Dear Doctor:
>
> We have received an unassigned claim for diagnostic tests furnished to the patient (Beneficiary Name), on (Date of Service). You are prohibited by §1842(n)(3) of the Social Security Act from billing or collecting any amount unless you indicate that "No purchased services are included" or, if the diagnostic test was purchased, you indicate who performed the test and what the supplier charged you. Some or all of the required information is missing from your patient's claim. If you have collected any amount from your patient, it must be refunded. This claim may be resubmitted if the required information is included.

D. Beneficiary Information Regarding Unassigned Claims

Carriers must notify the beneficiary that the physician is prohibited from:

- Billing the beneficiary when the necessary documentation is not supplied; and
- Billing or collecting an amount in excess of Medicare's payment, except for the deductible and coinsurance, when the required documentation is submitted.

(See chapter 21, for MSN messages.)

30.3.8 - Mandatory Assignment and Other Requirements for Home Dialysis Supplies and Equipment Paid Under Method II on Claims Submitted to Carriers

(Rev. 1, 10-01-03)

B3-3045.7

The DMERCs pay only on an assignment basis for home dialysis supplies and equipment furnished a beneficiary who has selected Method II.

Refer to chapter 8 and chapter 20 for more information.

30.3.9 - Filing Claims to a Carrier for Nonassigned Services

(Rev. 702, Issued: 10-07-05; Effective/Implementation Dates: N/A)

A General

Payment for Part B services furnished by a physician (or supplier) is made:

- To the beneficiary on the basis of an itemized bill (nonassigned claims); or

- To the physician (or supplier) who provided covered services on the basis of an assignment of benefit payments where the approved charge is the full charge for the services.

NOTE: For services furnished on or after September 1, 1990, physicians and suppliers must complete and submit both assigned and nonassigned Part B claims for beneficiaries.

B Conflicting Claims

Carriers must establish controls to detect and prevent payment for assigned and unassigned claims received for the same service (as well as duplicate assigned or duplicate unassigned claims.

If an appropriate assigned claim is received after an unassigned claim has been paid, carriers do not pay the subsequent claims. Where an enrollee's claim based on an unpaid bill is received and benefits are payable, carriers make payment to him/her unless there is some definite basis for believing that payment has been assigned, e.g., the physician or supplier is a "participating" provider or the bill from a nonparticipating physician or supplier shows that assignment may have been made.

Carriers are instructed to inform physicians that, if they wish to be sure of receiving Part B benefits, they should accept assignment at the time services are furnished and that their submission of claims to the carrier should not be unduly delayed.

30.3.10 - Carrier Submitted Bills by Beneficiary

(Rev. 1, 10-01-03)

B3-3040.1

Carriers do not make payment for non-receipted itemized bills without a Form CMS-1490S claim form signed by either the patient or his/her representative.

Note that CMS does not accept beneficiary submitted claims for items subject to mandatory assignment.

They also do not accept them for blood glucose test strips effective April 1, 2002.

30.3.11 - Carrier Receipted Bill - Definition

(Rev. 1, 10-01-03)

B3-3040.2

A receipted bill is a written acknowledgment by a person or organization furnishing specified covered services, which states that payment has been made for all services on the bill.

Where a receipted bill is submitted, benefits for the services shown on the bill should not be paid to the physician (or his/her supplier) since there can be no assignment. (See §20)

The bill itself bearing the words "received payment," "paid in full," "paid," or a phrase with the same meaning, is the best evidence of payment if it is signed or initialed by the physician (or his/her employee, etc.) or by the person or organization furnishing supplies or services. There will, however, be other evidence of payment that will be acceptable, such as machine-produced bills that clearly show the amount paid for each service. A rubber-stamp imprint on the bill which includes the name of the physician or other supplier is acceptable, absent a reason to

question it. It is also reasonable to accept, as evidence of payment, a cancelled check that is related in time and amount to a doctor's, or other Part B supplier's bill.

A bill paid by promissory note is treated as a "receipted bill" unless the bill shows on its face that the note is **not** given and accepted unconditionally as payment of the bill. For example, a bill marked "paid by promissory note" or "$25 paid in cash, balance paid by promissory note" is treated as a receipted bill. On the other hand, a bill marked "paid subject to payment on promissory note," or which otherwise clearly indicates that the promissory note was not unconditionally accepted in payment of it, is not a receipted bill.

30.3.12 - Carrier Annual Participation Program

(Rev. 702, Issued: 10-07-05; Effective/Implementation Dates: N/A)

For providers (including physicians and suppliers) who have enrolled in Medicare, to sign a participation agreement (Form CMS-460) is to agree to accept assignment for all covered services that are provided to Medicare patients. The benefits of signing a participation agreement include:

- No 5 percent reduction in the Medicare approved amount.
- Beneficiaries with Medigap coverage (private supplemental insurance) may assign the payment on the supplemental claim to the provider or supplier. Under the current mandatory Medigap (claim-based) crossover process, beneficiaries must assign payment on their claims to a participating provider or supplier as a condition for their claims to be forwarded to their Medigap insurer for payment of all coinsurance and deductible amounts due under the Medigap policy. The Medigap insurer, in turn, must pay the participating provider or supplier directly, thereby relieving the need of having to file a second claim. (Refer to the Medicare Claims Processing Manual, Chapter 28, Section 70.6, for more information regarding the eligibility-file based crossover process.)
- Listing in the Medicare Participation Physicians/Suppliers Directory (MEDPARD) that is posted on the carrier Web site.
- Participants receive direct and timely reimbursement from Medicare.

Refer to §30.3.1 for processing instructions for claims for practitioner services inadvertently submitted as unassigned.

A Eligibility

All practitioners and suppliers eligible to receive payments under Part B of Medicare may choose to enter into a participation agreement. This includes practitioners whose services are subject to mandatory assignment. The reason why it could still be appropriate for such practitioners to enter into a participation agreement is because the mandatory assignment provisions apply only to the particular practitioner service benefit (e.g., nurse practitioner services). Thus, for example, if a nurse practitioner is eligible to bill for, and is indeed billing under, Part B for something other than a nurse practitioner service (e.g., an EKG tracing), the mandatory assignment provision of the law does not apply to that other service. However, if the nurse practitioner has entered into a participation agreement, that agreement requires that the nurse practitioner accept assignment for any service for which he or she submits a Medicare Part B claim.

B Participation Enrollment Period

Carriers conduct an enrollment period on an annual basis in order to provide eligible practitioners and suppliers with the opportunity to enroll in or terminate enrollment in the participation program. They are given specific instructions each year regarding the dates during which the enrollment period is in effect.

C Circumstances in Which A Participating Physician or Supplier is Not Required to Accept Assignment for Covered Services

A participating physician or supplier is not required to accept assignment for covered services when an entity (other than the beneficiary), which is eligible to request direct payment from the Medicare program for the services, pays the physician or supplier and the physician or supplier accepts that payment as full payment.

For example, a private supplementary health benefits plan may pay the physician or supplier an amount, which the physician or supplier accepts as payment in full and then collect the Part B payment directly from the Medicare program. This procedure, called indirect payment or payment to organizations, permits a physician or supplier to submit a single claim for the Medicare and private plan benefits to the private health benefits plan. The physician or supplier may accept plan payment in excess of the Medicare approved charge.

The availability of this procedure depends on the extent to which health benefit plans are eligible and choose to use it. The indirect payment procedure is also available to nonparticipating physicians or suppliers.

D Entities Eligible to Enter Into Agreement to Be Participating Physicians or Suppliers

Any person or organization that is authorized to accept assignment of Medicare benefits for covered services may enter into a participating physician agreement. This includes (but is not limited to):

- Practitioners such as physicians, podiatrists, dentists, optometrists, and chiropractors;
- Hospitals, medical groups, and other entities which are authorized to bill and to receive payment for physician services;
- Organizations such as group practice prepayment plans, prepaid health plans, HMOs, and competitive medical plans which submit claims to Medicare carriers; and
- Suppliers such as independent physical therapists, medical equipment supply companies, independent laboratories, ambulance services, and portable X-ray suppliers.

E Applicable Rules When Physicians Work for a Hospital or Medical Group

The following rules apply when physicians work for (or are members of) a hospital, medical group, or other entity:

- Except in the case of university medical centers, if a hospital, medical group, or other entity bills and receives payment for physician services in the name of the entity (rather than have the individual physicians bill and receive payment in their own names), one participation agreement by the entity binds all physicians with respect to any services furnished for the entity. The individual physicians do not enter into participation agreements.

  NOTE: In university medical centers, when individual departments bill under the name and provider identification number of the department, decisions for or against participation can be made on a departmental basis.

- If a physician who is associated with a particular entity has an individual practice outside the scope of the practice for which the entity bills and receives payment, he or she may choose whether to participate with respect to his/her outside practice without regard to the participation status of the entity.
- If individual physicians who work for an entity bill and receive payment in their own names for the services furnished for the entity, they make individual decisions as to whether to participate. These decisions apply both to the physicians' services for the entity and to any outside practice.

F Services Subject to Agreement

The participation agreement applies to items and services for which payment is made on a fee-for-service basis by Medicare Part B carriers. A participating agreement applies to all items and services in all localities and under all names and identification numbers under which the participant does business.

The participant lists all names and identification numbers under which the participant submits claims to the carrier. This includes all names and numbers of the legal entity entering into the agreement, whether that entity is a sole proprietorship, partnership, or corporation.

If the participant opens offices in another carrier jurisdiction during the term of the agreement, he or she must file a photocopy of the agreement with that carrier.

G Acknowledgment of Receipt

Carriers acknowledge receipt of an agreement by sending the physician or supplier a photocopy of the agreement, which has been annotated with the effective date.

H Where to File Agreement

An agreement is valid if it is filed with any Medicare carrier in a timely manner.

A new participant must file an original agreement with the carrier in their region and a photocopy of the agreement by a date that CMS specifies on an annual basis with any other carriers which have assigned the participant a physician identification number and to which the participant submits claims. When submitting a photocopy of the agreement to a carrier, the new participant must identify in the letter transmitting the photocopy all names and identification numbers under which the participant submits claims to that carrier and indicate the name of the carrier to which the original agreement was mailed or delivered and the date it was mailed or delivered.

If the new participant enters into a valid agreement but does not also timely file a photocopy of the agreement with another carrier with which the participant does business, it may be too late for the participant to be listed in that carrier's directory of participating physicians. Nevertheless, the agreement is still binding, and it is important for the physician or supplier to submit a photocopy of the agreement to that carrier, even if late, because of advantages of the agreement, which are still available with late filing.

It is not necessary for the new participant to file a photocopy of the agreement with Palmetto GBA, the carrier for Railroad Retirement Board beneficiaries. The new participant's carrier will furnish Palmetto GBA with participating physician/suppler data (see Section 30.3.12.1.J. of this chapter).

Note that for DMEPOS suppliers, the NSC handles the participation agreements.

I Duration of Agreement

An agreement entered into, or continuing in effect, for a given year remains in effect through that year and may not be revoked during that period.

The agreement is renewed automatically for each 12-month period thereafter unless, during the enrollment period provided near the end of the 12-month period, the participant gives proper written notice of a wish to terminate the agreement at the end of its current term. Proper written notice means written notice to all carriers with whom the participant has filed the agreement or a copy of the agreement.

The CMS may terminate the agreement if it finds, after notice and opportunity for hearing, that the participant has substantially failed to comply with the agreement. There are also civil and criminal penalties, identical to those for assignment violations, which may be imposed for violation of the agreement.

Note that for DMEPOS suppliers, the NSC handles the participation agreements.

J When New Physician or Supplier in Area May Enter Into Agreement

A physician/supplier who has enrolled in the Medicare program and wishes to become a participating physician/supplier must file an agreement with a Medicare carrier within 90 days after either of the following events:

- The participant is newly licensed to practice medicine or another health care profession; or
- The participant first opens offices for professional practice or other health care business in a particular carrier service area or locality (regardless of whether the participant previously had or retains offices elsewhere).

If a physician has an arrangement with a hospital, medical group, or other entity under which the entity bills in its name for his/her services, changes that arrangement and then begins to bill in his/her own name, he/she is considered to be first opening offices, even though he/she practices in the same location.

The participating enrollment package is included with the CMS-855 form for new enrollees. Carriers must furnish a special participating agreement form for new physicians or suppliers upon request or at the time you assign the new physician or supplier an identification number.

When the agreement is filed on one of the above bases, it is effective on the date of filing, i.e., the date the participant mails (postmark date) the agreement to the carrier or delivers it to the carrier. The initial period of the agreement may be less than 12 months. Otherwise, the terms of the agreement are the same as those of an agreement entered into by other physicians or suppliers. The agreement applies to all services in all localities. The physician or supplier must submit the original agreement to the carrier in their region and photocopies to all carriers with whom he or she deals.

If a physician or supplier first enters into an agreement after publication of your directory, his or her name is not included in the directory until subsequent publication. This may not occur until the next annual publication date. Carriers must make the names of those physicians or suppliers entering into agreements after the initial deadline available on the toll free telephone lines as each physician or supplier enters into an agreement.

Note that for DMEPOS suppliers, the NSC handles the participation agreements.

30.3.12.1 - Carrier Participation and Billing Limitations
(Rev. 1335, Issued: 09-14-07, Effective: 05-23-07, Implementation: 10-01-07)

A. Participation Period

The annual physician and supplier participation period begins January 1 of each year, and runs through December 31. The annual participation enrollment is scheduled to begin on November 15 of each year. Carriers will receive the participation enrollment material under separate cover.

NOTE: The dates listed for release of the participation enrollment/fee disclosure material are subject to publication of the Final Rule.

B. Participation Enrollment and Fee Disclosure Process

The CMS will furnish carriers, via a separate instruction, with the participation materials used for the annual participation open enrollment period. Carriers mail the annual participation materials on a CD-ROM. Carriers must place the new fees and the anesthesia conversion factor(s) on their web site after the final rule is placed on display. Carriers shall not include the new fees on the CD-ROM. CMS has decided not to place the fees on the CD-ROM in order to have greater flexibility for making any last minute changes to the payment rate. Placing the fees on the carriers Web sites assures that providers will have the most current and correct fees available. The CMS transmits the MPFSDB electronically to carriers each year around mid-October.

Carriers must include additional supplemental materials in the CD-ROM to enhance its use and value to providers; and, are free to decide which supplemental materials to include. However, CMS may instruct all carriers to include a specific item(s) as part of the additional supplemental material on the CD-ROM (example: a note from the administrator, a special file, etc.). Carriers need to include an insert, or indicate on the envelope, instructions for providers on how to access the data on the CD. Carriers also need to include information regarding whom the provider can contact if assistance is required.

Each October, carriers should post a notice on their web site regarding the upcoming participation enrollment period reminding physicians and practitioners that the upcoming MPFS will be published on the carriers Web site after the physician fee schedule regulation is put on display.

The carrier mails the participation enrollment CD-ROM and/or hardcopy fee disclosure packages via first class or equivalent delivery service, and schedules the release of material so that providers receive it no later than date provided in a temporary instruction each year.

As part of the final mailing, carriers should send a final CD ROM to central office. The mailing address is:

Director of the Division of Practitioner Claims Processing
Centers for Medicare & Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

The CD-ROMs are sent to the following physicians and suppliers in accordance with the following guidelines no later than November 15 of each year, subject to the publication of the Final Rule:

- All physician specialties included in the 01-99 specialty range;
- Independently practicing occupational and physical therapists (specialty 65 and 67);
- Suppliers of diagnostic tests;
- Suppliers of radiology services (including portable x-ray suppliers-specialty 63);
- Multi-specialty clinics (specialty 70);
- Independent laboratories (specialty 69-since they can typically bill for anatomic pathology services paid under the Physician Fee Schedule);
- Mammography Screening Centers (specialty 45);
- Independent Diagnostic Testing Facilities (specialty 47);
- Audiologists (specialty 64); and
- Independently Billing Psychologists (specialty 62).

NOTE: Chiropractors and Mammography Screening Centers do not need to view the entire locality fee schedule report. Therefore, carriers may add separate headings on their web site listing the fee data for the procedure codes that they may receive payment.

Carriers send an annual participation announcement and a blank participation agreement to the following non-participating suppliers:

- Ambulatory Surgical Centers (ASCs) (specialty 49); (Although ASCs must accept assignment for ASC facility services, they may also provide and bill for non-ASC facility services, which do not have to be billed as assigned and which are therefore subject to a participation election); and,
- Supplier specialties other than 51-58; (Supplier specialties 51-58 will receive a separate enrollment package from the National Supplier Clearinghouse).

Carriers may create hard copy fee disclosure reports and send them to specialty 49, and supplier specialties other than 51-58, if cost effective to do so (e.g., carriers determine that fee disclosure to suppliers will reduce the number of more costly supplier inquiries for fee data). To minimize report programming costs, carriers may use the same format as the physician fee disclosure report. If they use the physician fee disclosure report format for supplier fee disclosure, carriers include a disclaimer advising the supplier that the non-participating fee schedule amounts and limiting charges do not apply to services or supplies unless they are paid for under the Physician

Fee Schedule. If carriers elect not to routinely disclose supplier fees with their participation enrollment packages, they must furnish suppliers with their applicable fee schedules or reasonable charge screens upon request.

Instructions for completing the enrollment process for non-durable medical equipment, prosthetic, orthotic, and supplies (DMEPOS) suppliers will be issued under separate cover. Those instructions will address the responsibilities of local carriers, durable medical equipment regional carriers (DMERCs), and the National Supplier Clearinghouse.

C. Minimum Requirements for Disclosure Reports for Posting on the Web and Hard Copies

Carriers must place the following information on the web sites and also in their hard copy disclosure reports.

- Carriers must use valid CPT and HCPCS codes for creating disclosure reports for physician fee schedule services when posting this information on the web. CMS provides carriers with complete locality data for all procedure codes with a status indicator of A, T, and R (for which CMS has established the RVUs) on the Medicare Physician Fee Schedule Database (MPFSDB). Included on the MPFSDB are payments for the technical portion of certain diagnostic imaging services (including the technical portion of global imaging services) that are capped at the Outpatient Prospective Payment System (OPPS) amount. Limiting charges are included on the annual disclosure reports of providers who may be subject to the nonparticipant fee schedule amount, if they elect not to participate for a calendar year. The limiting charge equals 115 percent of the nonparticipant fee schedule amount.

For the facility setting differential, the limiting charge is 115 percent of the nonparticipant fee for the differential amount.

The data for Locality Fee Schedule Reports are:

--Header Information – Locality identification (on each report page);

--Procedure Codes – Carriers must array all codes paid under the Physician Fee Schedule. They include global, professional component and technical component entries where applicable:

--Par Amount (nonfacility);

--Par Amount (facility based);

--Non-par Amount (nonfacility);

--Limiting Charge (nonfacility):

--Non-par Amount (facility based); and

--Limiting Charge (facility based);

--Footer Information – The following must be included on the fee disclosure reports:

1. The legend: "All Current Procedural Terminology (CPT) codes and descriptors are copyrighted (appropriate year) by the American Medical Association" (on each report page).

NOTE: The CMS has signed agreements with the American Medical Association regarding the use of CPT, and with the American Dental Association regarding the use of CDT, on Medicare contractor Web sites, bulletin boards and other contractor electronic communications. If the carrier uses descriptors, it must use short descriptors. The appropriate CPT copyright year must be inserted each year. For example: the 2006 CPT is copyrighted 2005; the 2007 CPT is copyrighted 2006; in each case, the appropriate year for the copyright is inserted by the contractor.

2. The legend: "These amounts apply when service is performed in a facility setting."

3. The legend: "The payment for the technical component is capped at the OPPS amount."

For the disclosure reports, the carrier shall also provide the anesthesia conversion factors.

In addition, the carrier includes language in a bulletin that provides an explanation of the facility-based fee concept (e.g., facility-based fees are linked to their own separate RVUs independent of the non facility RVUs).

D. Disclosure to Medical Societies and Other Parties

Carriers send first class or equivalent (e.g. UPS), free of charge, a complete fee schedule for the entire State (or your service area if it is other than the entire State) to State medical societies and State beneficiary associations. Carriers may negotiate with them as to the medium in which the information is to be furnished.

Carriers send local medical societies and beneficiary organizations a free copy of their respective locality fee schedule. If a fee schedule for the entire service area is requested by a local medical society or beneficiary organization, furnish one free copy. If more than one copy of a complete fee schedule for the carrier service area is requested, carriers charge for extra copies in accordance with the Freedom of Information Act (FOIA) rules. If a provider requests a fee schedule for a locality in which he/she has no office, carriers may charge them in accordance with FOIA rules.

E. Practitioners Subject to Mandatory Assignment

Some practitioners who provide services under the Medicare program are required to accept assignment for all Medicare claims for their services. This means that they must accept the Medicare allowed charge amount as payment in full for their practitioner services. The beneficiary's liability is limited to any applicable deductible plus the 20 percent coinsurance. The following practitioners must accept assignment for all Medicare covered services they furnish, and carriers do not send a participation enrollment package to these practitioners:

- Specialty 32 - Anesthesiologist assistants (AAs)
- Specialty 42 - Certified nurse midwives
- Specialty 43 - Certified registered nurse anesthetists (CRNAs)
- Specialty 50 - Nurse practitioners
- Specialty 68 - Clinical Psychologists
- Specialty 71 - Registered dietitians/nutritionists
- Specialty 73 - Mass Immunization Roster Billers
- Specialty 80 - Clinical Social Workers
- Specialty 89 - Clinical nurse specialists
- Specialty 97 - Physician assistants

NOTE: The provider type Mass Immunization Biller (specialty 73) can bill only for influenza and pneumococcal vaccinations and administrations. These services are not subject to the deductible or the 20 percent coinsurance.

Although these practitioners will not be invited to officially enroll in the Medicare participation program, carriers treat them as participating practitioners for purposes of various benefits available under that program (See Section 30.3.12 in this Chapter).

NOTE: Although these practitioners do not have to sign participation agreements, carriers must include them in the annual MEDPARD as participating. They also include Rural Health Centers.

Carriers may create and send hardcopy fee disclosure reports to these practitioners if cost effective to do so (e.g., the carrier determines that fee disclosure to these practitioners will reduce or minimize the number of more costly inquiries it receives for fee data). To minimize report programming costs, carriers may use the same format as the physician fee disclosure report. If they use the physician fee disclosure report format for practitioner fee disclosure, carriers include a disclaimer advising the practitioner that the non-participating fee schedule amounts and limiting charges do not apply to services they furnish. If carriers elect not to routinely disclose practitioner fees, they furnish applicable fees or reasonable charge screens upon request.

The Medicare Participation Agreement and general instructions are on the CMS Web site at http://www.cms.hhs.gov/cmsforms/downloads/cms460.pdf.

F. Supplier Fee Schedule Data

Refer to Chapter 23 for more information.

Clinical Laboratory Fee Schedule

Carriers must:

- Publish clinical diagnostic lab fees in a regularly scheduled bulletin or newsletter.
- Publish clinical laboratory fees in the following format:
    - Header Information: Name of fee schedule and State or locality (if less than State-wide) on each report page;
    - Procedure Code and Modifiers (Use procedure codes that are valid for appropriate year);
    - Fee Schedule Amount; and
    - Footer Information: The legend "All Current Procedural Terminology (CPT) codes and descriptors are copyrighted (appropriate year) by the American Medical Association." (on each report page).

Information regarding release of this data will be issued under separate cover.

DMEPOS Fee Schedule:

Instructions for furnishing DMEPOS fee schedule data will be issued annually by CMS.

G. Fee Schedule Printing Specifications

Carriers are to produce hardcopy disclosure material for no more than two percent of their total number of providers. Carriers have the discretion to produce either one or two percent hardcopy versions. The hard copy fee schedules are to be mailed to providers who are **unable** to access the carrier Web site (i.e., do not have internet access). For those providers, carriers must print fee schedules on 8-1/2 by 11-inch paper, and use a print size that accommodates up to 15 characters per inch. The CMS prior approval for smaller print must be requested in writing from the RO. Requests are to be accompanied by print samples to assist the RO in assessing report readability.

H. Date of HCPCS Update

The annual HCPCS update occurs on January 1 of each year. The annual HCPCS update file will be released electronically in October of each year.

I. Medicare Participation Physicians/Suppliers Directory (MEDPARD)

Annually, within 30 days following the close of the annual participation enrollment process, carriers produce a directory listing only Medicare participating physicians and suppliers and post it on their Web site. Carriers do not print hardcopy participation directories (i.e., MEDPARDs) without regional office prior authorization and advance approved funding for this purpose. Carriers load MEDPARD equivalent information on their Internet Web site. Carriers notify

providers via regularly scheduled newsletter as to the availability of this information and how to access it electronically. Carriers also inform hospitals and other organizations (e.g., Social Security offices, area Administration on Aging offices, and other beneficiary advocacy organizations) how to access MEDPARD information on the carrier Web site.

Carriers that receive MEDPARD inquires from beneficiaries who do not have access to their Web site will ascertain the nature and scope of each request and furnish the desired MEDPARD participation information via telephone or letter.

(a). Contents

Each directory has two parts. Part I shows the correct Specialty, Name, Address and Telephone Number of each participating Physician, Supplier and Group by geographic area. The address in the directory must be the address of the physician's/supplier's place of business and not a Post Office box number. Part II includes only the name and telephone number of all Physicians, Suppliers and Groups contained in Part I listed in alphabetic sequence. Telephone numbers may not be omitted. Edit the listings to assure that everyone listed in Part I is also listed in Part II (multiple addresses may be included if appropriate); physicians are listed only once by name in Part II.

When you have only the group name for participating group practices, you may list the names of physician(s) within the group, but only at the group's request. For groups which so request, list the physicians under the group name in alphabetical sequence. Indicate an individual physician's specialty if it differs from other specialties. Show only the group address and telephone number. (**NOTE:** A group practicing physician who also has solo practices may appear more than once if he is participating in more than on entity.)

Do not list the names of hospital based physicians.

Where a beneficiary would not have personal choice access to a group, (e.g., the group accepts patients by referral only), list only the group name and address. Note that it accepts patients by referral only.

If a physician or supplier has multiple service locations, accommodate this in the directories to the extent possible with the information on the provider file and information obtained during the participation enrollment process.

List all <u>independent</u> RHCs in your area, not necessarily jurisdiction, in the MEDPARD. They are required to accept Medicare payment on claims as payment in full and, therefore, meet the acceptance criteria for a MEDPARD listing even though a participating agreement has not been signed. Do not group independent RHCs with physicians in the directory. List them separately on a full or partial page under the wording shown below. Show the name, address and telephone number of each. Treat the RHC as a group and list only the clinic name and telephone number in Part II of the MEDPARD (the alphabetical listing). Use an indicator so the beneficiary can distinguish between a group and a RHC.

The following wording must appear above the list of independent RHCs:

"Rural Health Clinics (RHCs) agree to accept payment by the Medicare program as full payment for their services, except for the applicable deductible and coinsurance amounts for which the beneficiary is responsible. The independent RHCs in the area are listed below:"

(b). Organization (Geographic, Physician/Supplier/Group, Alphabetic)

Prepare a separate MEDPARD for each geographic area, e.g., depending upon size, one for each metropolitan area or one for each county or group of counties. Your plan must be submitted to RO for approval prior to production. Divide each MEDPARD into two parts.

Divide Part I first alphabetically by geographical location. Within each location, list each specialty. Under the specialty, alphabetically list Physicians, Suppliers and Groups with their addresses and telephone numbers. Include optometry and podiatry as specialties and not as suppliers. Add lay terminology to all specialty headings, e.g., ophthalmology (eye disease), so that they are easily understood by the beneficiary. Do not list any "miscellaneous" or "unknown" specialties. These should default to "General Practice" or "Other."

Part II is a straight alphabetical listing of all Physicians, Suppliers and Groups in the directory, with their telephone numbers. If a physician's or supplier's name and address are the same and listed more than once in Part I, list that individual only once in Part II.

(c). Paper, Print, Binding

Carriers with regional office prior authorization and advanced funding can prepare the MEDPARD in hardcopy (booklet) form on white offset book paper. Size the directory by the number of participating physicians/suppliers in your area. Do not exceed 8 1/2 by 11 inches. Use print comparable to 10 point type or larger which improves the readability of the directory. Use type set print rather than computer listings. Put all geographical location and specialty headings in bold, uppercase lettering.

Bind the directory in an attractive and distinctive cover which displays the red, white and blue emblem of the Medicare participating physician. This emblem must show association with "U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES Centers for Medicare & Medicaid Services." clearly indicate on the front cover that this is a Medicare directory of participating physicians/suppliers. Date the MEDPARD so that older editions will not be confused with subsequent ones.

The back cover should function as an envelope for the directory. Put your name and return address in the upper left corner. Reserve the upper right corner for 3rd class postage. Use address labels, generated from your records of directory requests, to make the directory a self-mailer.

Carriers with regional office prior authorization and advanced funding for the MEDPARD in booklet form must produce it within 45 days following the close of the annual participation enrollment process.

(d). Interpretive Information

Each directory must have a Table of Contents. Include detailed instructions on the organization of the directory. Place your name and toll-free telephone number at the bottom of the instructions in the front of the directory. Include detailed instructions on "how to use the directory," i.e., to locate a participating physician or supplier in a specific area: first, find the correct county in the table of contents; second, look below the county for the city name and find the city's page number; third, turn to the appropriate page and look for the physician or supplier specialty you need; fourth, look for the names of physicians or suppliers in that specialty. At the top of the instruction page, include the statement: "This directory contains the names, addresses, telephone numbers, and specialties of MEDICARE PARTICIPATING physicians and suppliers. MEDICARE PARTICIPATING physicians and suppliers have agreed to accept assignment on all Medicare claims for covered items and services."

(e). Dissemination of MEDPARD Information

Within your Medicare service area, inform the following groups how to access the MEDPARD on the carrier Web site:

- Beneficiaries who request to view the MEDPARD; and
- Physicians, suppliers, groups, and clinics listed in the directory who request to view the MEDPARD.

Within 30 days after the close of the annual participation enrollment period, carriers inform the following individuals/groups of the availability of their local MEDPARD on the carrier Web site:

- Congressional offices;
- Quality Improvement Organizations;
- Senior citizen groups and other beneficiary advocacy organizations;
- Social Security Offices;
- State area agencies of the Administration on Aging; and
- Hospitals.

If you receive inquiries from a customer who does not have access to your Web site, ascertain the nature and scope of each request and furnish the desired MEDPARD participation information via telephone or letter.

(f). Alternative Method

You may produce the MEDPARD on diskettes or transmit it electronically. Send alternative mediums to those entities or individuals who wish to receive them in forms other than paper.

Carriers add their local MEDPARDs to their Web sites and inform the various organizations who use the directory of its availability. Publicize Web site MEDPARD access information at least annually in your regularly scheduled newsletters.

(g). Reporting Requirements

Carriers with regional office prior authorization and advanced funding for the MEDPARD in hardcopy form must maintain a record of all hardcopy directories that were distributed. Submit an initial printing/distribution/cost report within 90 days after the close of the annual participation enrollment period. Send the report to your RO and copy CO at the following address:

Director, Division of Practitioner Claims Processing
Centers for Medicare & Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

Include the following information in your initial report: (1) the number of MEDPARDs initially printed; (2) the number of MEDPARDs distributed to each category in (e) above within 60 days after the close of the annual participation enrollment period; and (3) the cost per directory distributed (e.g., printing and distribution costs).

Submit a year end report no later than 45 days after the end of the fiscal year. On the year end report, include the actual number of MEDPARDs printed and the number of MEDPARDs distributed to each category during the fiscal year. Include the cost per directory distributed on your initial report and include an explanation as to the reason for the adjusted year end cost figure.

J. Furnishing Participating Physician/Supplier Data to Railroad Retirement Board (RRB)

(a). Furnishing RRB with participating information for the general enrollment period:

Within 30 days after the annual participation enrollment period has closed, all carriers must furnish their entire physician/supplier file. The file is to be transmitted to RRB at the same time the MEDPARD is being posted on the carrier Web site. Submit the file in the following format:

1. File Specifications

Carriers send the Provider Participation File (PPF) via CD or cartridge to the RRB carrier. Enter the external label for the file as follows:

FROM:
TO:
DATE:
DATA SET NAME: "Provider Participation File" (PPF).

A. Header Type Specifications

	Field	Position	Picture	Remarks/Field Value

1.	Label	1-3	x (3)	"PPF"
2.	Carrier No.	4-8	9 (5)	Carrier number assigned by CMS.
3.	Date File Updated	9-14	x (6)	MMDDYY

B. Detail Record Specifications.--

	Field	Position	Picture	Remarks/Field Value
1.	TIN/EIN	1-9	9 (9)	Tax identification number used to report income (1099).
2.	UPIN	10-15	x (6)	Unique Physician Identification Number. If not available or applicable, fill with spaces.
3.	Locality	16-17	x (2)	Locality or area designation associated with TIN/EIN.
4.	Current Year Par Indicator	18	x (1)	"Y" = Par "N" = Nonpar
5.	Current Year of Practice	19	9 (1)	1 = First year 2 = Second year 3 = Third year 4 = Fourth year 5 = Established Provider
6.	Carrier PIN	20-29	x(10)	The provider's carrier-assigned provider identification number.
7.	Physician/Supplier Name	30-54	x (25)	Last Name = 14 First Name = 10 Middle Initial = 1 or Corporate Name = 25 The format for provider name is a total of 25 bytes. Individual providers must have a comma between last name, first name, and middle initial (i.e., Smith, John, M). Space one position between multiple words in corporate names (i.e., Jones Medical Supply).
8.	Physician/Supplier Address	55-110	x (56)	Street Address = 30 City = 15 State Code = 2 Zip Code = 9 Space between numerics and words and space between multiple words. Left justify zip codes. The first five zip code spaces must be numeric and the last four spaces can either be numeric or spaces. Separate street address, city and state with commas, e.g., "1234 Security Boulevard, Baltimore,MD,567891234"

Carriers send the physician/supplier file to:

Attn: Manager, Provider Enrollment
Palmetto GBA
Railroad Retirement Board
2743 Perimeter Pkwy
Building 200, Suite 400
Augusta, GA 30909

(b). Furnishing RRB with participating information for other than the general enrollment period:

After furnishing an annual provider file, inform the RRB carrier, on a flow-basis, of all participating doctors, practitioners and suppliers who enroll after the annual general enrollment period. Carriers send the RRB carrier copies of participation election forms received from physicians, practitioners and suppliers who enrolled after the annual enrollment and, therefore, were not included on the provider file transmitted to the RRB carrier. Transmit copies of such participation enrollment forms via cover letter or fax. Include the following information in your cover letter or fax cover sheet:

- Tax Identification (TIN) or Employer Identification Number (EIN);
- UPIN or NPI when required;
- Locality designation associated with the TIN/EIN;
- Current Year of Practice;
- Carrier PIN or NPI when required; and
- Participation Effective Date.

NOTE: If any of the above information is entered/displayed on the participation agreement form being transmitted, you do not need to include that piece of information in your cover letter or you may state "see attached participation agreement" for that particular item of information.

Carriers send photocopy participation agreements by mail to:

Attn: Manager, Provider Enrollment
Palmetto GBA
Railroad Retirement Board
2743 Perimeter Pkwy
Building 200, Suite 400
Augusta, GA 30909

For participation agreements transmitted via fax call (706) 855-3049.

K. Key Implementation Dates

A detailed schedule of key implementation dates will be provided in an annual temporary instruction in advance of receiving the MPFS Database file. The following outlines significant disclosure activities and anticipated implementation dates. A detailed schedule is provided under separate cover by CMS.

Carriers must:

October:

- Download fee schedules
- Download HCPCS

November:

- Release participation materials and disclosure reports;
- Furnish yearly physician fee schedule amounts to CMS for carrier priced codes;

December:

- Furnish DMEPOS fee schedule and physician fee schedules to State Medicaid Agencies;
- Furnish conversion factors and inflation indexed charge data to the carrier State Medicaid Agencies;
- Process participation elections and withdrawals; and,
- Send a complete fee schedule to the State medical societies and State beneficiary associations.

January:

- Implement annual fee schedule amounts;
- Implement annual HCPCS update;
- Send an updated provider file to the Railroad Retirement Board; and
- Load MEDPARD equivalent information on the carrier Web site.

February:

- Submit participation counts to CMS Central Office via CROWD.

30.3.12.2 - Carrier Participation Agreement

(Rev. 1, 10-01-03)

B3-17001.1

MEDICARE

PARTICIPATING PHYSICIAN OR SUPPLIER AGREEMENT

Name(s) and Address of Participant*	Physician or Supplier Identification Code(s)

The above named person or organization, called “the participant,” hereby enters into an agreement with the Medicare program to accept assignment of the Medicare Part B payment for

all services for which the participant is eligible to accept assignment under the Medicare law and regulations and which are furnished while this agreement is in effect.

1. Meaning of Assignment - For purposes of this agreement, accepting assignment of the Medicare Part B payment means requesting direct Part B payment from the Medicare program. Under an assignment, the approved charge, determined by the Medicare carrier, shall be the full charge for the service covered under Part B. The participant shall not collect from the beneficiary or other person or organization for covered services more than the applicable deductible and coinsurance.

2. Effective Date - If the participant files the agreement with any Medicare carrier during the enrollment period, the agreement becomes effective _____.

3. Term and Termination of Agreement - This agreement shall continue in effect through December 31 following the date the agreement becomes effective and shall be renewed automatically for each 12-month period January 1 through December 31 thereafter unless one of the following occurs:

a. During the enrollment period provided near the end of any calendar year, the participant notifies in writing every Medicare carrier with whom the participant has filed the agreement or a copy of the agreement that the participant wishes to terminate the agreement at the end of the current term. In the event such notification is mailed or delivered during the enrollment period provided near the end of any calendar year, the agreement shall end on December 31 of that year.

b. The Centers for Medicare & Medicaid Services may find, after notice to and opportunity for a hearing for the participant, that the participant has substantially failed to comply with the agreement. In the event such a finding is made, the Centers for Medicare & Medicaid Services will notify the participant in writing that the agreement will be terminated at a time designated in the notice. Civil and criminal penalties may also be imposed for violation of the agreement.

_____	_____	_____
Signature of participant (or authorized representative of participating organization)	Title (if signer is authorized representative of organization)	Date

Office phone number (including area code)_____

* List all names and identification codes under which the participant files claims with the carrier with whom this agreement is being filed.

Received by (name of carrier)

Effective date _____

Initials of carrier official_____

to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850 and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington D.C. 20503.

30.3.12.3 - Carrier Rules for Limiting Charge

(Rev. 1, 10-01-03)

B3-17002

Effective January 1, 1991, the maximum allowable actual charge (MAAC) for non-participating physicians is replaced by the limiting charge. The limiting charge is the maximum that the non-participating provider may charge the beneficiary. It also effectively **replaces** the special charge limits for overpriced procedure, anesthesia associated with cataract and iridectomy surgery, A-mode ophthalmic ultrasound and intraocular lenses (IOLs, and designated specialty, because the limiting charge is always less than or equal to the special charge limits.

The limiting charge applies to all of the following services/supplies, regardless of who provides or bills for them, if the services/supplies are covered by the Medicare program and are provided:

- Physicians' services;
- Services and supplies furnished incident to a physician's services that are commonly furnished in a physician's office;
- Outpatient physical therapy services furnished by an independently practicing physical therapist;
- Outpatient occupational therapy services furnished by an independently practicing occupational therapist;
- Diagnostic tests; and
- Radiation therapy services (including x-ray, radium, and radioactive isotope therapy, and materials and services of technicians).

NOTE: This means that, effective for services/supplies provided on or after January 1, 1994, the limiting charge applies to drugs and biologicals provided incident to physicians' services, to physical therapy services provided by independently practicing physical therapists, and to occupational therapy services provided by independently practicing occupational therapists. These changes are made because of provisions in OBRA 1993. OBRA 1993 expanded the limiting charge to apply to services/supplies which the law permits Medicare to pay for under the physician fee schedule methodology but which Medicare has chosen to pay for under some other method. "Incident to" drugs and biologicals, previously excluded from the limiting charge because of their exclusion from physician fee schedule payment, are, effective January 1, 1994, still excluded from physician fee schedule payment but subject to the limiting charge. Also, OBRA 1993 applies the limiting charge to all of the above listed services/supplies, regardless of who provides or bills for the services/supplies. No longer are services of suppliers and other nonphysicians, such as physician assistants, nurse midwives, and independently practicing physical and occupational therapists, excluded from the limiting charge.

Physicians, non-physician practitioners, and suppliers must take assignment on claims for drugs and biologicals furnished on or after February 1, 2001, under §114 of the Benefits Improvement and Protection Act (BIPA).

Effective January 1, 1993, the limiting charge is 115 percent of the fee schedule amount for nonparticipating physicians.

EXAMPLE:

Participating fee schedule amount	$2000
Nonparticipating fee schedule amount	$1900 (95% of $2000)
Limiting charge	$2185 ($1900 times 1.15)

Charges to either a payer for whom Medicare is secondary or to a payer under the indirect payment procedure are not subject to the limiting charge if the physician accepts the payment received as full payment (i.e., if there is no payment by the beneficiary).

The provider may round the limiting charge to the nearest dollar if they do so consistently for all services.

30.3.13 – Charges for Missed Appointments

(Rev. 1279; Issued: 06-29-07; Effective: 10-01-07; Implementation: 10-01-07)

CMS's policy is to allow physicians and suppliers to charge Medicare beneficiaries for missed appointments, provided that they do not discriminate against Medicare beneficiaries but also charge non-Medicare patients for missed appointments. The charge for a missed appointment is not a charge for a service itself (to which the assignment and limiting charge provisions apply), but rather is a charge for a missed business opportunity. Therefore, if a physician's or supplier's missed appointment policy applies equally to all patients (Medicare and non-Medicare), then the Medicare law and regulations do not preclude the physician or supplier from charging the Medicare patient directly.

The amount that the physician or supplier charges for the missed appointment must apply equally to all patients (Medicare and non-Medicare), in other words, the amount the physician/supplier charges Medicare beneficiaries for missed appointments must be the same as the amount that they charge non-Medicare patients (whatever amount that may be).

With respect to Part A providers, in most instances a hospital outpatient department can charge a beneficiary a missed appointment charge without violating its provider agreement and 42 CFR 489.22. Because 42 CFR 489.22 applies only to inpatient services, it does not restrict a hospital outpatient department from imposing charges for missed appointments by outpatients. In the event, however, that a hospital inpatient misses an appointment in the hospital outpatient department, it would violate 42 CFR 489.22 for the outpatient department to charge the beneficiary a missed appointment fee.

Medicare does not make any payments for missed appointment fees/charges that are imposed by providers, physicians, or other suppliers. Charges to beneficiaries for missed appointments should not be billed to Medicare.

If contractors receive any claims for missed appointment charges, the following reason code and MSN messages should be used to deny the claims—

Reason Code 204: This service/equipment/drug is not covered under the patient's current benefit plan.

MSN messages:

16.59 - Medicare doesn't pay for missed appointments.
16.59 – Medicare no paga por citas médicas a las que no se presentó.

40 - Termination of Provider Agreement

(Rev. 1, 10-01-03)

A3-3008, A2-2800

A provider as defined in Chapter 5 of the Medicare General Information, Eligibility, and Entitlement Manual, may voluntarily terminate its participation in the program or have it terminated by the Secretary for cause.

40.1 - Voluntary Termination

(Rev. 1, 10-01-03)

A3-3008.1, A2-2800.1, RHC-330, Pub 9-124

According to 42 CFR 489.52, a provider that wishes to terminate its agreement to participate in the Medicare program may do so by: (1) filing with CMS a written notice stating its intention to terminate its agreement; and (2) informing CMS of the date upon which it wishes the termination to take effect. The CMS may approve the date proposed by the provider or set a different date no later than six months after the date of the provider's notice.

The effective date of termination may be less than six months following CMS' receipt of the provider's notice of its intention to terminate if CMS determines that termination on that date would not:

- Unduly disrupt the furnishing of services to the community; or
- Otherwise interfere with the effective and efficient administration of the Medicare program.

If a provider sends the FI a written notice of its intention to terminate its agreement, the FI should forward the notice to the CMS RO. The date of receipt of the notice by the FI will be considered the date of filing in determining the date of termination.

The RO promptly notifies the FI when it learns from other sources that a provider wishes to terminate its participation in the program, and keeps the FI informed of the status of the provider's request. It is the responsibility of the FI, as necessary, to make preliminary arrangements for filing of the cost report, and to adjust any interim payments, accelerated payments, of current financing payments to avoid overpayments. Final notice of termination of the provider's agreement is formally given to the FI by the RO via Form CMS-2007.

As soon as the termination date is established, the RO instructs the provider to notify the public that it is voluntarily terminating its provider agreement. The public notice should be published in the local newspapers with the largest circulation, as soon as possible, but not less than l5 days before the effective termination date. A provider that wishes to terminate its provider agreement

should also file a Form CMS-855A with the FI requesting a voluntary termination of its Medicare billing number.

40.1.1 - Close of Business

(Rev. 1, 10-01-03)

A2-2800.2, RHC-330

A provider may temporarily or permanently cease all business (Medicare and non-Medicare), and not timely notify the RO that it is ceasing operations. The FI may be made aware very early of an impending closure due to its fiscal relationship with the provider. Where the FI learns that a provider is ceasing operations, the FI should immediately notify the RO and also take necessary action to avert an overpayment.

A provider is considered to have voluntarily terminated its agreement if it ceases to furnish services to the community. The termination is effective after the last day of business of the provider.

40.1.2 - Change of Ownership

(Rev. 1, 10-01-03)

HHA-145, HO-145, SNF-145, RHC-331, RHC-332

When an organization having a provider agreement undergoes a change of ownership in accordance with the principles articulated in 42 CFR Part 489 and §3210 of the State Operations Manual, the agreement with the existing provider is automatically assigned to the new owner so that there is no interruption in service. However, a new agreement with updated information must subsequently be signed and a Form CMS-855A must be submitted by both the old and new owners. Only if the provider, under the change of ownership, meets the applicable requirements for approval can the agreement be executed. For FQHCs, these requirements include PHS approval.

An organization that plans to change ownership must give advance notice of its intention so that a new agreement can be negotiated or so that the public may be given sufficient notice in the event that the new owners do not wish to participate in the Medicare program. A provider that plans to enter into a lease arrangement (in whole or in part) should also give advance notice of its intention.

A change of ownership occurs, for example, when:

- A sole proprietor transfers title and property to another party;
- In the case of a partnership, there is an addition, removal, or substitution of a partner unless the partners expressly agree otherwise;
- An incorporated organization merges with an incorporated entity that is approved by the program and the latter entity is the surviving corporation. It also occurs when two or more corporate providers consolidate and the consolidation results in the creation of a new corporate entity;
- An unincorporated organization (a sole proprietorship or partnership) becomes incorporated; or
- The lease of all or part of an entity constitutes a change of ownership of the leased portion.

When an organization's agreement is terminated, whether by the entity or by CMS, no payment is available to the provider for services it furnishes to Medicare beneficiaries on or after the effective date of the termination.

40.1.3 - Expiration and Renewal-Nonrenewal of SNF Term Agreements

(Rev. 1, 10-01-03)

A3-3008.3, and Pub 100-1, Chapter 5

All agreements with skilled nursing facilities must be for a specified term of up to 12 full calendar months with fixed expiration dates unless termination occurs according to §§40.1 and 40.2. The agreement expires at the close of the last day of its specified term and is not automatically renewable from term to term. When the term of an agreement is extended (see §40.3.1), the close of the last day of its specified term is the close of the day of the extension of the agreement. Thus, when the term of an agreement is extended, the provider's participation in the program continues, and the agreement does not expire until the close of the last day to which it has been extended.

Since an agreement with an SNF is not automatically renewable from term to term, each term agreement with an SNF requires that the SNF qualify for participation and that its agreement be accepted for filing. A participating SNF may, however, continue its participation under the agreement **form** previously accepted for filing provided the SNF continues to qualify for participation, and the agreement form is again accepted for filing and renewed for a term which begins on the date immediately following the close of the last day of the prior term of the agreement. When the requirements for participation continue to be met, there is no limit to the number of times that the SNF's agreement form may again be accepted and renewed for a specified term.

When the time-limited agreement (including an agreement which has had its term extended) is renewed on the day immediately following the close of the last day of its term, the expiration of the agreement is not considered a termination of participation in the program.

However, once an agreement with an SNF is (1) not renewed, or (2) voluntarily terminated by the SNF, or (3) involuntarily terminated (including cancellations) by the Secretary, the previously accepted agreement cannot again be accepted and renewed. In such cases, the SNF is required to execute and file a new agreement if it is again found eligible to participate in the Medicare program and must submit a Form CMS-855A as a **brand new provider**. The effective date of the new agreement must be determined in accordance with regulatory provisions (42 CFR 489.13).

The Secretary's determination not to accept and renew a SNF agreement is a determination relating to the qualifications of the SNF in the period immediately following the close of the SNF's existing agreement; and the SNF is entitled to request a reconsideration of the determination in accordance with the appeals procedure contained in 42 CFR Part 405 Subpart O. Such determinations involve a finding that:

- Based on a State agency resurvey and recertification, the SNF will not be approved for a period of certification because it is out of compliance with one or more conditions of participation;
- Based on a State agency resurvey and recertification, the SNF continues to be out of compliance with the same standard(s) in the conditions of participation as were found out

of compliance during the term of the agreement and the facility will not be approved for a new period of certification; or

- The SNF has violated the terms of its agreement or the provisions of title XVIII or regulations promulgated thereunder.

In cases of nonrenewal by the Secretary, the FI's role is the same as for involuntary terminations. (See §40.2.1).

40.2 - Involuntary Terminations

(Rev. 1, 10-01-03)

A3-3008.2, RHC-331

The Secretary may terminate an agreement with a provider if it is determined that the provider:

- Is not complying fully (or substantially in the case of SNFs) with the provisions of the agreement or with the applicable provisions of title XVIII of the Act and regulations;
- No longer meets the appropriate conditions (requirements for SNFs) of participation;
- Has failed to supply information which is necessary to determine whether payments are due or were due and the amounts of such payments; or
- Refuses to permit examinations of fiscal and other records, including medical records.

The cancellation of a SNF agreement is viewed as an involuntary termination of the agreement by the Secretary for cause. Such actions involve a finding that the SNF has not satisfactorily completed its written plan providing for the correction of deficiencies with respect to one or more of the standards in the applicable requirements of participation, or that the facility has not made substantial effort and progress in correcting such deficiencies.

A provider which is dissatisfied with the Secretary's determination terminating its agreement is entitled to request a hearing thereon in accordance with the appeals procedures contained in 42 CFR Part 498. There is **no** reconsideration step before the opportunity for a hearing.

For the FI's role in processing involuntary terminations, see §40.2.1.

NOTE: The involuntary termination of a hospital's approval authorizing it to provide extended care services, i.e., to be a swing bed facility, (see Chapter 3) does not automatically result in the involuntary termination of the hospital's agreement relating to the provision of hospital services.

40.2.1 - Processing Involuntary Terminations

(Rev. 1, 10-01-03)

A2-2800.3

When there has been a determination by the RO that an institution or agency no longer qualifies as a provider of services, the RO notifies the provider in writing that termination of its agreement has been recommended. A copy of this notification is sent to the servicing FI so that it is aware of the potential termination. However, the FI should not divulge this information.

If CMS central office decides that termination of the agreement is appropriate, it establishes the effective date of termination, notifies the provider in writing, and notifies the RO. The RO immediately arranges for publication of the required notice to the public and sends a formal notice of termination to the FI via Form CMS-2007 (see §40).

40.2.2 - FI Report on Provider Deficiencies

(Rev. 1, 10-01-03)

A2-2801, A2-2801.1

Most terminations of provider agreements are based primarily on health and safety factors, but fiscal considerations may also play an important role in the decision to terminate. The provider agreement and the Social Security Act impose certain obligations on the provider with respect to costs, charges, financial records, and related matters.

Deficiencies in these areas may, of themselves, or in the combination with deficiencies in health and safety factors, constitute significant reasons for termination.

Upon receipt of a State agency recommendation of termination, the RO notifies the servicing FI and requests a report concerning any reimbursement aspects that might constitute additional grounds for termination. The FI's report should include such information as: cost reports not filed; cost reports past due and a description of the action taken; the provider's refusal to permit the necessary examination of its fiscal records; status of any cost report settlements still pending; provisions for recoupment of current financing and accelerated payments; amount of unpaid billings for covered services rendered which may be used as an offset against any overpayment; and any potential overpayment in the current period.

40.2.2.1 - Subsequent Communications With Provider

(Rev. 1, 10-01-03)

A2-2801.2

Following release of the report to the RO, any communication between the provider and the FI related to reimbursement or other problems that could constitute grounds for termination should be immediately reported to the RO. The RO should also be informed **in advance** of any subsequent onsite visits to the provider regarding such matters. Unrecorded communications, visits, or correctional allegations that were not known and taken into consideration by CMS before final termination may cause embarrassment or even result in failure to sustain the termination action at later stages of the proceedings, particularly if the issue goes to a formal hearing. Even after final termination action, any such contacts with the provider may be pertinent to proper handling of the case by CMS, and therefore the FI must promptly forward the information to the RO.

40.3 - Readmission to Medicare Program After Involuntary Termination

(Rev. 1, 10-01-03)

A2-2804

After the involuntary termination of its agreements, a health facility cannot participate again as a provider unless:

- The reasons for termination of the prior agreement have been removed, and
- There is reasonable assurance that they will not recur.

The RO makes the final decision as to whether the facility is eligible for readmission. In doing so, it reviews the case in its entirety and makes the final decision regarding the following:

- Correction of deficiencies upon which the termination was based;

- Reasonable assurance of continued compliance, and
- Reasonable assurance of availability of information pertinent to reasonable cost reimbursement.

The RO will then process the case in the same way as an initial certification.

40.3.1 - Effective Date of Provider Agreement

(Rev. 1, 10-01-03)

A2-2804.1

Since one of the key issues is whether the facility has furnished “reasonable assurance” that the reasons for termination will not recur, the provider agreement cannot be effective before the date on which “reasonable assurance” is deemed to have been provided.

Generally, a facility will be required to operate for a period of 60 days without recurrence of the deficiencies that were the basis for the termination. The provider agreement will be effective with the end of the 60-day period. If corrections were made before filing the new request for participation, the period of compliance before filing the new request will be counted as part of the 60-day period; however, in no case can the effective date of the provider agreement be earlier than the date of the new request for participation.

Exceptions to the 60-day period of compliance will be made where:

- Structural changes have eliminated the reasons for termination. “Reasonable assurance” will be considered established as of the date such structural changes were completed. The effective date will be that date or the date of filing the new request to participate, whichever is later.
- "Reasonable assurance” is not established even after 60 days of compliance, because of the facility’s history of misrepresentation or of making temporary corrections and then relapsing into the old deficiencies that were the basis for termination. The effective date in such cases would be the earliest date after 60 days at which “reasonable assurance” is deemed to have been established, or the filing date of the new request to participate, whichever is later.

40.3.2 - Fiscal Considerations in Provider Readmission to Medicare Program After Involuntary Termination

(Rev. 1, 10-01-03)

A2-2805, RHC-334

Upon being notified that a terminated provider has filed a request for participation, the RO telephones the FI which previously serviced the facility and requests information concerning any unresolved financial problems (e.g., an overpayment that must be recovered) so that the RO can determine whether such issues must be resolved before the facility is permitted to participate.

The RO also contacts the FI that will service the facility upon readmission (this may be either the FI which previously serviced the facility or another FI) and asks it to make sure that the facility has made adequate provisions for furnishing the financial and accounting data required under the participation agreement. Where termination was based on fiscal considerations, either entirely or in combination with deficiencies in health and safety factors, the FI will also be requested to check and report on whether the deficiencies have been corrected. This report should include:

- The basis for believing that the deficiencies that led to termination of the provider agreement have (or have not) been corrected.
- If corrected, a description of:
    - When and how this was done;
    - The evidence showing compliance has existed for a sufficient period of time; and
    - The FI's reasons for concluding that the deficiencies will not recur.
- A description of any other fiscal and reimbursement problems and the basis of believing these should (or should not) affect certification of the facility.

40.4 - Payment for Services Furnished After Termination, Expiration, or Cancellation of Provider Agreement

(Rev. 980, Issued: 06-14-06, Effective: 10-01-06, Implementation: 10-02-06)

The CMS RO will inform the FI upon termination, expiration or cancellation of a provider agreement.

Effective with the date a provider agreement under §1866 of the Act (or swing bed approval) terminates, expires, or is cancelled, no payment is made to the provider under such agreement for:

A Termination of Hospital Agreement

Inpatient hospital services (including inpatient psychiatric hospital services) and swing bed extended care services furnished on or after the effective date of the hospital's termination, except that payment can continue to be made for up to 30 days of inpatient hospital services and/or swing bed extended care services (total of no more than 30 days) furnished on or after the termination date to beneficiaries who were admitted (at either the acute or extended care level) prior to the termination date.

B Termination of Swing Bed Approval

Swing bed extended care services furnished on or after the effective date of the termination of the hospital's swing bed approval, except that payment can continue for up to 30 days of extended care services furnished on or after the termination date to beneficiaries who were admitted (at either the acute or extended care level) prior to the termination date.

C Skilled Nursing Facility Termination

Posthospital extended care services furnished on or after the effective date of termination of the agreement, where such agreement has been voluntarily terminated by the provider (§40.1) or involuntarily terminated by the Secretary for cause (§40.2). However, payment can continue to be made for up to 30 days of posthospital extended care services furnished on and after the termination date to beneficiaries who were admitted prior to the termination date.

D Expiration SNF

Posthospital extended care services furnished on or after the date which follows the last day of the specified term of the agreement, where such agreement has expired at the close of the last day of its specified term (§40.3), except that where the agreement has not been renewed, payment can be made for up to 30 days of posthospital extended care services furnished on and

after the date which follows the last day of the specified term of such agreement to beneficiaries who were admitted on or before such last day.

E HHA and Hospice

Home health and hospice services furnished under a plan which is established on or after the termination date, except that if the plan was established before the termination date, payment is made for services for up to 30 days following the effective date of termination.

F Other

Other items and services, including outpatient physical therapy or speech-language pathology and diagnostic services, furnished on or after the effective date of termination or, in the case of an expiration or cancellation of an SNF agreement, on or after the day following the close of such agreement.

40.4.1 - Reviewing Inpatient Bills for Services After Suspension, Termination, Expiration, or Cancellation of Provider Agreement, or After a SNF is Denied Payment for New Admissions

(Rev. 1, 10-01-03)

A3-3600.3

See §40.4 for provisions for payment following a termination or expiration of a provider agreement. A SNF may be denied payment for new admissions, but not readmissions, as an option to termination of its provider agreement for noncompliance with one or more requirements 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 of termination or expiration.

EXAMPLE:

Effective date of denial of payment - 9-30

Beneficiary admitted before 9-30 - pay for covered Part A or B services

Beneficiary admitted on or after 9-30 - 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.

The contractor is notified of SNF payment denials through the Form CMS-2007. It must install appropriate edits or other safeguards to prevent incorrect payments to the provider.

The contractor obtains 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.

40.4.2 - Status of Hospital or SNF After Termination, Expiration, or Cancellation of Its Agreement

(Rev. 1, 10-01-03)

A3-3699.3.C

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-1500, 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, the designated emergency FI handles billings as follows:

Region I	Associated Hospital Services of Maine (dba, Maine Blue Cross and Blue Shield
Region III	Veritus
Region IV	First Coast Services
Region VI	Trailblazers
Region VII	Blue Cross and Blue Shield of Nebraska
Region IX	United Government Services

Regions II, V, VIII, and X have no designated FI.

Claims for services provided in a Religious Nonmedical Healthcare Institutions (domestic and foreign) are sent to Riverbend Government Benefits Administrator (GBA) in Tennessee.

The following CMS Web address provides a complete list of addresses and phone numbers for FIs and carriers: http://cms.hhs.gov/contacts/incardir.asp**.**

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 for the provider to submit two bills. The provider submits 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.

40.5 - FI/Carrier/DMERC Responsibilities for Informing Providers of Changes

(Rev. 1, 10-01-03)
A3-3600.7

Contractors must inform providers in writing of changes in policy and procedures and the effective date before making changes. They must send these notices at least thirty days before changes are put into effect to give providers time to adjust. When a shorter implementation schedule is unavoidable, the contractor must provide the notice as soon as it is available.

For electronic data interchange (EDI) instructions, the contractor must notify providers of changes at least 60 to 90 days in advance.

Contractors must conduct provider training on an as needed basis and initiate regular contact with the provider community through organizations that represent them. It must develop continuing staff contacts with these organizations to resolve issues of mutual concern.

The contractor must provide adequate telephone service so that providers can receive prompt answers to claims status and processing questions. It must implement procedures and training in telephone units to ensure that its employees furnish consistent and correct information and make appropriate referrals for specialized information.

50 - Filing a Request for Payment With the Carrier or FI

(Rev. 1, 10-01-03)
A3-3301

Except as provided in §50.1.2 and §50.1.6, payment may not be made for Medicare services furnished under Part A or Part B unless the beneficiary or a designated representative files a timely written request for payment and the provider files a timely claim. (See §§80 for an explanation of time limits.)

If the beneficiary does not file a request upon admission or start of care, it may be filed later with the provider or (less preferably) with an FI or carrier or CMS. The provider still must file a claim for payment (billing).

50.1 - Request for Payment From the Carrier or FI

(Rev. 1, 10-01-03)
A3-3302

50.1.1 - Billing Form as Request for Payment

(Rev. 1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

Each of billing forms (Health Insurance Claim Form CMS-1500; and Request for Medicare Payment, Form CMS-1490) contains a patient's signature line or reference to the patient signature incorporating the patient's request for payment of benefits, authorization to release information, and assignment of benefits. When the billing form is used as the request for payment, there must be a signature, except when the provisions in §50.1.2 apply.

The Medicare Uniform Institutional Provider Bill (UB-04), Form CMS-1450 does not contain an actual line for the patient's signature. 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. The institutional claim form contains a provider representative signature, which includes a certification that a request for payment has been obtained from the patient. See §50.1.2 for requirements for providers.

Billing forms are used when electronic media claims (EMC) billing is not feasible.

50.1.2 - Beneficiary Request for Payment on Provider Record - UB-04 and Electronic Billing (Part A and Part B)

(Rev. 1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

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

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

Request for Payment

_____ _____

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 an HHA under a plan of treatment the request is effective for the plan of treatment. For other services 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 carrier and FI inspection on request.

The FI and carrier must make periodic audits of signature files selected on a random basis. The carrier may arrange with the FI for the latter to perform this function on its behalf for carrier claims submitted by providers.

50.1.3 - Signature on the Request for Payment by Someone Other Than the Patient

(Rev. 1, 10-01-03)

A3-3302.5, B3-3008

General

If at all practical the patient should sign the request on the provider's records at the start of care, or upon admission for hospital or SNF admissions. However, where a beneficiary is unable to execute a request for payment because of a mental or physical condition, the request may be executed on his/her behalf by a legal guardian, representative payee (a person designated by the Social Security Administration or other governmental agency to receive an incompetent beneficiary's monthly cash benefits), relative, friend, representative of an institution providing him/her care or support, or of a governmental agency providing assistance. A physician or supplier (or his/her employee) cannot request payment for services furnished except under circumstances fully documented to show that the enrollee is unable to sign and that there is no other person who could.

For this purpose, "an institution providing him/her care" includes a long-term care facility, a hospital (whether psychiatric or general), a SNF, and a nursing home. Only an employee of the institution or agency may be authorized to act as its representative to sign claims on behalf of incompetent patients.

The name of the incompetent person should be shown on the signature line of the Request for Medicare Payment (or equivalent authorization retained in the file, followed by "by" and the signature and address of the requestor. The requestor, other than a representative payee, should attach a statement to the Request for Medicare Payment explaining his/her relationship to the beneficiary and the reason the beneficiary cannot sign. If such a statement is not submitted, FIs and carriers must obtain an explanation if other development is needed or if the physician or supplier (or employee) has signed. Except in such cases, FIs and carriers should not delay processing the claim to obtain an explanation.

Carriers and FIs are permitted to honor an otherwise properly completed and submitted claim signed by the administrator (or other authorized employee) of a nonprofit long-term care facility on behalf of a resident who has given the facility the necessary power of attorney (P/A). (A long-term care facility, as distinguished from a nursing or other SNF, is an institution that contractually provides room, board, medical, and other necessary services to people who commonly enter and remain there for life, even when in good health. It may include a skilled nursing unit.) Carriers and FIs may assume that the facility has the necessary authority when the administrator enters in the signature space the resident's name, followed by "P/A," the administrator's signature, his title, and the name of the home. A signature on behalf of a competent enrollee based on a P/A granted to anyone other than an authorized official of a nonprofit long-term care facility is not acceptable.

NOTE: The fact that such a request may be honored does not mean that payment can be made to the requestor.

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, should be asked and permitted to sign on his behalf.

A. Provider Signs Request

If, at the time of admission, 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 FI.

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 its 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 indicate in the provider record "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 the estate, or by any of the persons or institutions (including an authorized official of the provider) who could have signed it had the patient 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 §50.1.4.

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 the relationship to the patient and the circumstances which made it impracticable for the patient to sign. The provider will retain the statement in its. The FI 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 FI 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.

50.1.4 - Request for Payment as a Claim for HI Entitlement

(Rev. 1, 10-01-03)

A3-3302.6

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 the Social Security Administration (SSA). Even though an individual meets all eligibility requirements, if the necessary application is not filed before death, the individual cannot be entitled to Part A benefits and no payment can be made under the HI program for 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 the patient may have a card even though the necessary application has not been filed. To protect the eligible patient, the 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 six months of the date of SSA's written notice to a proper applicant of the need for such application. Chapter 2 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.

50.1.5 - Refusal by Patient to Request Payment Under the Program

(Rev. 1, 10-01-03)

A3-3302.7

A patient on admission to a hospital or skilled nursing facility may refuse to request Medicare payment and agree to pay for the services out of their 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 a 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 that requires a patient to have covered services paid for under Medicare if the patient 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 requests payment by Medicare (because another insurance will not pay or for another reason) and requests payment under the health insurance program within the prescribed time limit, the provider must submit a Medicare claim, and refund to the patient any amounts the beneficiary paid in excess of the permissible charges.

Where a patient who has declined to request payment dies, the right to request payment may be exercised by the legal representative of the estate, by any of the persons or institutions mentioned in the second paragraph of §50.1.3, 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 that would not otherwise be paid for and

allows a refund to the estate or to a person or institution that paid the bill on behalf of the deceased.

See §70 for filing claims for payment and for associated time limits.

The provider may charge the beneficiary for covered services where the beneficiary refuses to file.

50.1.6 - When Beneficiary Statement is Not Required for Physician/Supplier Claim

(Rev. 980, Issued: 06-14-06, Effective: 10-01-06, Implementation: 10-02-06)

A. Enrollee Signature Requirements

A request for payment signed by the enrollee must be filed on or with each claim for charge basis reimbursement except as provided below. All rules apply to both assigned and unassigned claims unless otherwise indicated.

1. When no enrollee signature required:
    a. Claim submitted for diagnostic tests or test interpretations performed in a medical facility which has no contact with enrollee.
    b. Unassigned claim submitted by a public welfare agency on a bill which is paid.
    c. Enrollee deceased, bill unpaid and the physician or supplier agrees to accept Medicare approved amount as the full charge.
2. When signature by mark is permitted: The enrollee is unable to sign his name because of illiteracy or physical handicap.
3. When another person may sign on behalf of the enrollee:
    a. Enrollee who is resident of a nonprofit retirement home gives power of attorney to the administrator of the home.
    b. Enrollee physically or mentally unable to transact business: The request may be signed by a representative payee, legal representative, relative, friend, representative of an institution providing the enrollee care or support, or of a governmental agency providing him/her assistance.
    c. Enrollee physically or mentally unable to transact business and full documentation is supplied that the enrollee has no one else to sign on his behalf: The physician, supplier, or clinic may sign.
    d. Enrollee deceased and bill paid or liability assumed: Person claiming payment should sign. If Form CMS-1500 was signed before the enrollee dies, claimant should sign separate request for underpayment.
4. When request retained in file may cover extended future period:
    a. Assignment in files of welfare agency covers all services furnished during the period when the enrollee is on medical assistance.
    b. Authorization in files of organization approved under §30.2.8.3 covers all services paid for by that organization under that procedure.

c. Assignment in the files of group practice prepayment plan covers services furnished by the plan during the period of the enrollee's membership.

d. Assignment in the files of a participating provider (hospital, SNF, home health agency, outpatient physical therapy or speech-language pathology provider or comprehensive rehabilitation facility) or ESRD facility covers physician services for which the provider or facility is authorized to bill, and may cover the physician services furnished in the provider or facility as follows:

- Inpatient services - effective for period of confinement.
- Outpatient services - effective indefinitely.

e. Assignment in files of individual physician, supplier (except in the case of unassigned claims for rental of durable medical equipment) or qualified reassignee under §30.2 is effective indefinitely.

B. Physician (Supplier) Signature Requirement

The rules below apply to both assigned and unassigned claims unless otherwise indicated.

1. In a claim for services furnished by an individual physician (or supplier), the physician may:

   a. In an unassigned claim, provide an itemized bill on his own letterhead - no physician signature required. A Form CMS-1500 on which the name or identification code of the physician has been stamped or preprinted in item 31 is the equivalent of the physician's own letterhead.

   b. Sign item 31 of Form CMS-1500.

   c. Sign one time certification letter for machine-prepared claims submitted on other than paper vehicles.

   d. Authorize an employee (e.g., nurse, secretary) to enter the physician's signature in item 31 of the Form CMS-1500.

      i. Manually

      ii. By stamp-facsimile or block letters

      iii. By computer

   e. Authorize a nonemployee agent, e.g., billing service or association, to enter as in d. above, the physician's signature in item 31 of the Form CMS-1500, followed by the agent's name, title, and organization (e.g., a billing agent might enter by stamp "Dr. Tom Jones by Robert Smith, Secretary, Ajax Billing Service"). Alternatively, the agent may simply enter the physician's signature.

2. In a claim by a clinic, hospital, or other entity authorized to bill and receive payment in its name for the services of the physician, the entity may:

   a. In an unassigned claim, provide an itemized bill on its letterhead-no signature necessary. A Form CMS-1500 on which the name or identification code of the billing entity has been stamped or preprinted in item 8 is the equivalent of the reassignee's own letterhead.

b. Have authorized official sign in item 25 of the Form CMS-1500 (item 13 of Form CMS-1554, item 6 of Form CMS-1556).

c. Have authorized official sign one-time certification letter for machine-prepared claims submitted on other than paper vehicles.

d. Have authorized employee, e.g., a secretary, enter authorized official's signature in item 25 of the Form CMS-1500 (item 13 of Form CMS-1554, item 6 of Form CMS-1556) as in 1d.

e. Have nonemployee agent enter authorized official's signature in item 25 of the Form CMS-1500 (item 13 of Form CMS-1554, item 6 of Form CMS-1556) as in 1.e.

50.1.7 - Definition of a Claim for Payment

(Rev. 1, 10-01-03)

A3-3305.1, B3-3004, A3-3312.2, B3-3000

For those billing carriers and DMERCS, a claim does not have to be on a form but may be any writing submitted by or on behalf of a claimant, which indicates a desire to claim payment from the Medicare program in connection with medical services of a specified nature furnished to an identified enrollee. It is not necessary that this submission be recorded on a CMS claim form, that the services be itemized or that the information submitted be complete (e.g., a note from the enrollee's spouse, or a bill for ancillary services in a nonparticipating hospital, could count as a claim for payment).

The writing must contain sufficient identifying information about the enrollee to permit the obtaining of any missing information through routine methods, e.g., file check, microfilm reference, mail or telephone contact based on an address or telephone number in file. Where the writing is not submitted on a claims form, there must be enough information about the nature of the medical or other health service to enable the contractor with claims processing jurisdiction to determine that the service was apparently furnished by a physician or supplier.

The definition of a part B claim for purposes of timely filing is any writing submitted by or on behalf of a claimant, which indicates a desire to claim payment from the Medicare program for medical services of a specified nature to an identified enrollee. For example, a note from the enrollee's spouse or a bill for ancillary services in a nonparticipating hospital could constitute a claim for payment.

If such a claim is mailed or delivered to SSA, CMS or to any carrier or FI within the time limit, the claim is filed timely provided the necessary claims information (e.g., Form SSA-1490 and itemized bill in the case of an enrollee-filed claim) is submitted within the time limit or, if later, within six months after the end of the month in which the claimant is advised to furnish it, e.g., if the notice is provided February 2, the claim must be filed by close of business August 31. See Statement of Intent instructions in §70.7.

Note that electronic claims must be in NSF or ANSI format, and when HIPAA becomes effective, electronic claims must be in ANSI X12N format. Refer to chapter 24, chapter 25, and chapter 26 for information about ANSI X12 formats.

50.1.8 - Establishing Date of Filing - Postmark Date - Carriers

(Rev. 1, 10-01-03)

A3-3305.2, A3-3305.3

Whenever the last day for timely filing of a claim falls on a Saturday, Sunday, legal holiday, or other day all or part of which is a non-work-day for Federal employees because of Federal statute or executive order, the claim will be considered timely if it is filed on the next workday.

Where the claim is submitted to the carrier by mail, if it is material and to the advantage of the provider, the claim can be considered filed on the day the envelope was postmarked in the United States. Thus, where an undated claim is received by the carrier in the mail early in the month after the filing date, the envelope should, if practical, be retained. If, in such a case, an envelope with a legible postmark is not available, a 7-day tolerance will usually apply. For example, a claim for services provided in May 2000 received by a carrier on or before January 10, 2002, may be presumed by the carrier, in the absence of evidence to the contrary, to have been mailed on or before January 2, 2002, (which is the date the time limit expires because it is the first Federal workday after Saturday, December 31). This rule will be applicable where the claim was mailed within the contiguous 48 States and the District of Columbia and received by a carrier within such States. In other cases, the reasonable tolerance may be longer and will depend on the usual mailing time under the particular circumstances.

50.2 - Frequency of Billing for Providers

(Rev. 1231; Issued: 04-27-07; Effective: 12-03-07; Implementation: 12-03-07)

Different types of providers are paid based on different payment policies depending upon the circumstance of the provider. These payment policies are described in detail in the chapters related to the provider type. The following billing requirements are to strike a balance between program administration efficiency and maintaining cash flow for providers.

Standard System Maintainer (SSM) shall ensure that providers adhere to these requirements.

50.2.1 – Inpatient Billing From Hospitals and SNFs

(Rev. 1706; Issued: 03-27-09; Effective Date: 10-01-06; Implementation Date: 04-27-09)

Non PPS Hospitals and SNFs

Inpatient services in TEFRA hospitals (i.e., hospitals excluded from inpatient prospective payment system (PPS), cancer and children's hospitals) and SNFs are billed:

- Upon discharge of the beneficiary;
- When the beneficiary' benefits are exhausted;
- When the beneficiary's need for care changes; or
- On a monthly basis.

Hospitals in Maryland that are under the jurisdiction of the Health Services Cost Review Commission are subject to monthly billing cycles.

Providers shall submit a bill to the FI when a beneficiary in one of these hospitals ceases to need a hospital level of care (occurrence code 22). FIs shall not separate the occurrence code 31 and occurrence span code 76 on two different bills. Each bill must include all applicable diagnoses

and procedures. However, interim bills are not to include charges billed on an earlier claim since the "From" date on the bill must be the day after the "Thru" date on the earlier bill.

SNF providers shall follow the billing instructions provided in Chapter 6 (SNF Inpatient Part A Billing), Section 40.8 (Billing in Benefits Exhaust and No-Payment Situations) for proper billing in benefits exhaust and no-payment situations.

PPS Hospitals

Inpatient acute-care PPS hospitals, inpatient rehabilitation facilities (IRFs), long term care hospitals (LTCHs) and inpatient psychiatric facilities (IPFs) may interim bill in at least 60-day intervals. Subsequent bills must be in the adjustment bill format. Each bill must include all applicable diagnoses and procedures.

All inpatient providers will also submit a bill when the beneficiary's benefits exhaust. This permits them to bill a secondary insurer when Medicare ceases to make payment. Initial inpatient acute care PPS hospital, IRF, IPF and a LTCH interim claims must have a patient status code of 30 (still patient). When processing interim PPS hospital bills, providers use the bill designation of 112 (interim bill - first claim). Upon receipt of a subsequent bill, the FI must cancel the prior bill and replace it with one of the following bill designations:

- For subsequent interim bills, bill type 117 with a patient status of 30 (still patient); or

- For subsequent discharge bills, bill type 117 with a patient status other than 30. *(See Chapter 25 for a list of valid patient discharge status codes)*

All inpatient providers must submit bills when any of the following occur, regardless of the date of the prior bill (if any):

- Benefits are exhausted;
- The beneficiary ceases to need a hospital level of care (all hospitals);
- The beneficiary falls below a skilled level of care (SNFs and hospital swing beds; or
- The beneficiary is discharged.

Effective December 3, 2007, when a beneficiary's Medicare benefits exhaust in an IPF or an LTCH, the hospital is allowed to submit a no pay bill (TOB 110) with a patient status code 30 in 60 day increments until discharge. They no longer have to continually adjust bills until physical discharge or death. The last bill shall contain a discharge patient status code.

These instructions for hospitals and SNFs apply to all providers, including those receiving Periodic Interim Payments (PIP). Providers should continue to submit no-pay bills until discharge.

50.2.2 - Frequency of Billing to FIs for Outpatient Services

(Rev. 980, Issued: 06-14-06, Effective: 10-01-06, Implementation: 10-02-06)

Repetitive Part B services furnished to a single individual by providers that bill FIs shall be billed monthly (or at the conclusion of treatment). The instructions in this subsection also apply

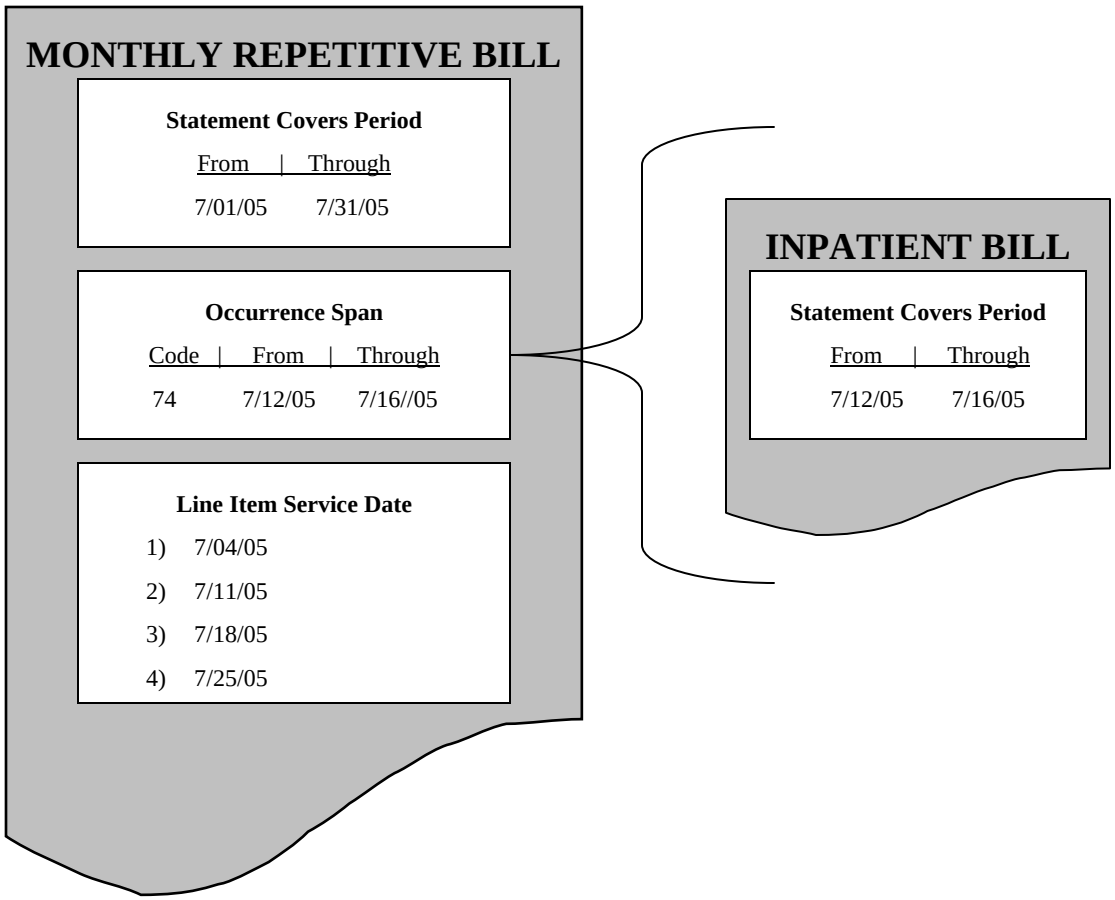
to hospice services billed under Part A, though they do not apply to home health services. Consolidating repetitive services into a single monthly claim reduces CMS processing costs for relatively small claims and in instances where bills are held for monthly review. Services repeated over a span of time and billed with the following revenue codes are defined as repetitive services:

Type of Service	**Revenue Code(s)**
DME Rental	0290 – 0299
Respiratory Therapy	0410, 0412, 0419
Physical Therapy	0420 – 0429
Occupational Therapy	0430 – 0439
Speech-Language Pathology	0440 – 0449
Skilled Nursing	0550 – 0559
Kidney Dialysis Treatments	0820 – 0859
Cardiac Rehabilitation Services	0482, 0943

Hospitals in Maryland that are under the jurisdiction of the Health Services Cost Review Commission are subject to monthly billing cycles.

Where there is an inpatient stay, or outpatient surgery, or outpatient hospital services subject to OPPS, during a period of repetitive outpatient services, one bill for repetitive services shall nonetheless be submitted for the entire month as long as the provider uses an occurrence span code 74 on the monthly repetitive bill to encompass the inpatient stay, day of outpatient surgery, or outpatient hospital services subject to OPPS. CWF and shared systems must read occurrence span 74 and recognize the beneficiary cannot receive non-repetitive services while receiving repetitive services, and consequently, is on leave of absence from the repetitive services. This permits submitting a single, monthly bill for repetitive services and simplifies FI review of these bills. The following is an illustration explaining this scenario:

Leave of Absence "Carve-Out" Example

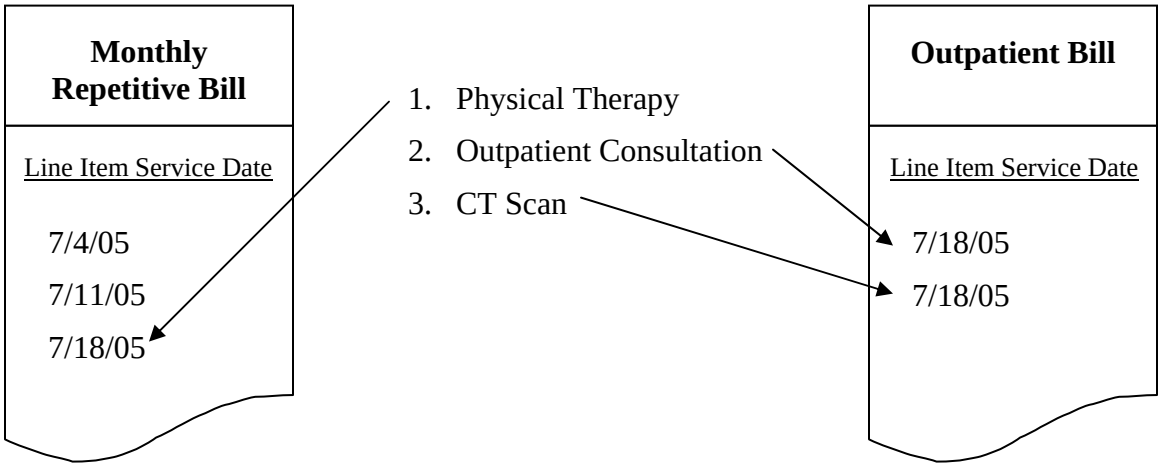


Any items and/or services in support of the repetitive service shall be reported on the same claim even if the revenue code(s) reported with those supported services are not on the repetitive revenue code list (**NOTE:** Supporting items and/or services are those in which are needed specifically in the performance of the repetitive service. Examples may include disposable supplies, drugs or equipment used to furnish the repetitive service).

However, to facilitate APC recalibration, do not report unrelated one-time, non-repetitive services that have the same date of service as a repetitive service (even if both the non-repetitive service and the repetitive service are paid under OPPS). If a non-repetitive OPPS service is provided on the same date as a repetitive service, report the non-repetitive OPPS services, along with any packaged and/or services related to the non-repetitive OPPS service, on a separate OPPS claim. For example, if a chemotherapy drug is administered on a day a repetitive service is also rendered, report the chemotherapy drug, its administration, its related supplies, etcetera, on a separate claim from the monthly repetitive services claim. Similarly, as shown below in the illustration, "Example: Monthly Repetitive Billing Procedure," a physical therapy treatment (which is a repetitive service because it is reported under a revenue code on the repetitive service list) is administered on the same day an outpatient consultation and a CT scan are furnished, report the physical therapy service on the claim with the other physical therapy services provided

during the applicable month. Report the visit for the consultation and the CT scan on a separate claim.

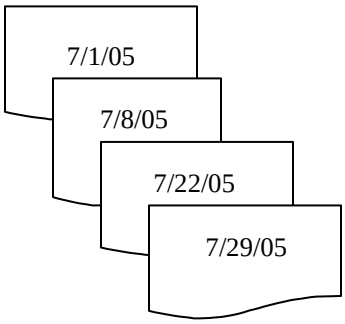
Example: Monthly Repetitive Billing Procedure



Revenue codes usually reported for chemotherapy and radiation therapy are not on the list of revenue codes that may only be billed monthly. Therefore, hospitals may bill chemotherapy or radiation therapy sessions on separate claims for each date of service. However, because it is common for these services to be furnished in multiple encounters that occur over several weeks or over the course of a month, hospitals have the option of reporting charges for those recurring services on a single bill, as though they were repetitive services. If hospitals elect to report charges for recurring, non-repetitive services (such as chemotherapy or radiation therapy) on a single bill, they must also report all charges for services and supplies associated with the recurring service on the same bill. The services may all be reported on the same claim or billed separately by date of service as illustrated below:

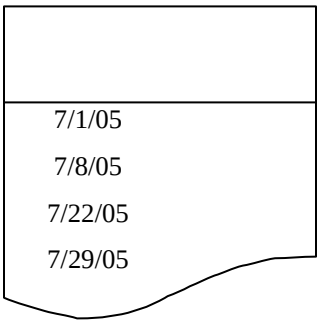
Billing Procedures for Recurring Services Not Defined as Repetitive

1) Submit multiple bills for each date of service (include only the recurring service and its related services):



OR

2) Submit a monthly bill for all line item dates of service (for the entire month's recurring services with all services related to the recurring services):



Indian Health Service Hospitals, Maryland hospitals, as well as hospitals located in Saipan, Guam, American Samoa, and the Virgin Islands are not subject to OPPS. In addition, hospitals that furnish only inpatient Part B services are also exempt from OPPS. Bills for ambulatory surgery in these hospitals shall contain on a single bill all services provided on the same day as the surgery except kidney dialysis services, which are billed on a 72X bill type. Non-ASC services furnished on a day other than the day of surgery shall not be included on the outpatient surgical bill.

See Chapter 16 for clinical diagnostic lab services paid under the fee schedule when included with outpatient bills for other services.

FIs periodically review bills from providers known to be furnishing repetitive services to determine if they are billing more frequently than proper. Techniques that may be used are:

- Sample review of bills to determine if most are for a monthly period (by using from and thru dates or number of services). This may be done manually or electronically. FIs may rely on informal communications from their medical review staff, and

FIs should educate providers that bill improperly. FIs shall:

- Return bills with an explanation and request proper billing to providers that continue to bill improperly.
- Not return bills where the treatment plan is completed indicating discontinued services because the beneficiary dies or moves.

50.2.3 - Submitting Bills In Sequence for a Continuous Inpatient Stay or Course of Treatment

(Rev. 552, Issued: 04-29-05, Effective: 10-01-05, Implementation: 10-03-05)

When a patient remains an inpatient of a SNF, TEFRA hospital or unit, swing-bed, or hospice for over 30 days, these providers submit a bill every 30 days. (See §50.2.2 for Frequency of Billing.) Claims for the beneficiary are to be submitted in service date sequence. The shared system must edit to prevent acceptance of a continuing stay claim or course of treatment claim until the prior bill has been processed. If the prior bill is not in history, the incoming bill will be returned to the provider with the appropriate error message.

When an out-of-sequence claim for a continuous stay or outpatient course of treatment is received, FIs will search the claims history for the prior bill. They do not suspend the out-of-sequence bill for manual review, but perform a history search for an adjudicated claim. For bills other than hospice bills, if the prior bill is not in the finalized claims history, they return to the provider the incoming bill with an error message requesting the prior bill be submitted first, if not already submitted. The returned bill may only be resubmitted after the provider receives notice of the adjudication of the prior bill. A typical error message would be as follows:

> Bills for a continuous stay or admission or for a continuous course of treatment must be submitted in the same sequence in which the services are furnished. If you have not already done so, please submit the prior bill. Then, resubmit this bill after you receive the remittance advice for the prior bill.

For a hospice claim that is out of sequence, the FI searches their claims history. If the FI finds the prior claim has been received but has not been finalized (for instance, it has been suspended

for additional development), they do not cause the out of sequence claim to be returned to the provider. Instead, they hold the out of sequence claim until the prior claim has been finalized and then process the out of sequence claim. If the prior hospice claim has not been received, the out of sequence hospice claim is returned to the provider with an error message as described above. FIs shall perform editing to ensure hospice claims are processed in sequence after any necessary medical review of the claims has been completed.

Since hospice claims received out of sequence do not pass all required edits, they do not meet the definition of "clean" claims defined in §80.2 below. As a result, they are not subject to the mandated claims processing timeliness standard and are not subject to interest payments. FIs will enter condition code 64 on the out of sequence claims they are holding when awaiting the processing of the prior claims to indicate that they are not "clean" claims.

50.2.4 - Reprocess Inpatient or Hospice Claims in Sequence

(Rev. 1, 10-01-03)

A3-3603.2, definition of spell of illness from MIM 3035

If a beneficiary, provider, or a secondary insurer notifies the FI that out-of-sequence processing increased the liability of the beneficiary or a secondary insurer, the FI confirm this through reviewing claims processed in its history and the Common Working File (CWF) records. If liability is increased, FIs cancel the previously processed bills for that spell-of-illness and reprocess all bills in the spell-of-illness or benefit period in sequence. This may require coordination with another FI where the beneficiary was an inpatient in different hospitals with different FIs or received hospice services from separate hospices with different FIs. The CWF utilization record must be corrected to properly allocate full, coinsurance, and lifetime reserve days, as applicable. The CWF utilization record must also be corrected to reflect the correct hospice periods.

This is an issue only when the beneficiary is an inpatient for more than 30 days (in the same or different facilities) during the spell of illness or benefit period. A spell of illness or benefit period is a period of time (consecutive days) during which covered services furnished to a patient, up to certain specified maximum amounts, may be paid for by the hospital insurance plan. This situation occurs most often when long-term care hospitals are involved. For hospice claims, out of sequence processed claims must be reprocessed to maintain the integrity of hospice election periods. If an FI is contacted by another FI or any regional office (RO), they cancel all affected claims and reprocess in accordance with the instructions from the lead FI or RO.

The lead FI is the one contacted by a provider, beneficiary, or other insurer complaining of improper payment as result of out-of-sequence billing. The lead FI will coordinate actions with any other FIs involved to cancel and reprocess the bills, as necessary. For inpatient stays, the lead FI verifies that the provider, beneficiary, or other insurer was adversely affected and coordinates these actions directly with any other affected FI to cancel any out-of-sequence bills they processed and posted. For hospice claims, the lead FI verifies an out-of-sequence claim(s) impacted the hospice election period. The lead FI coordinates actions to cancel any bills posted out-of-sequence directly with any other affected FI. All FIs must reprocess all bills based on the actual sequence of the beneficiary's stays at the various providers or on the actual sequence of hospice services. The lead FI controls the sequence in which the bills are processed and posted to CWF.

If the lead FI experiences any difficulty with another FI, they contact their RO to coordinate with any necessary ROs for other affected FIs' bills.

This approach is to be used only when the beneficiary, provider, or other insurer has increased liability as a result of out-of-sequence processing or when the hospice election periods are incorrect. It is not to be used if the liability stays the same, e.g., if deductible is applied on the second stay instead of the first, but there is no issue with regard to the effective date of supplementary coverage.

50.3 - When an Inpatient Admission May Be Changed to Outpatient Status

(Rev. 1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

Payment is made under the Hospital Outpatient Prospective Payment System (OPPS) for Medicare Part B services furnished by hospitals subject to the OPPS, and under current payment methodologies for hospitals not subject to OPPS. "Outpatient" means a person who has not been admitted as an inpatient but who is registered on the hospital or critical access hospital (CAH) records as an outpatient and receives services (rather than supplies alone) directly from the hospital or CAH.

In some instances, a physician may order a beneficiary to be admitted to an inpatient bed, but upon reviewing the case later, the hospital's utilization review committee determines that an inpatient level of care does not meet the hospital's admission criteria.

The CMS has obtained a new condition code from the National Uniform Billing Committee (NUBC), effective April 1, 2004:

Condition Code 44--Inpatient admission changed to outpatient – For use on outpatient claims only, when the physician ordered inpatient services, but upon internal utilization review performed before the claim was originally submitted, the hospital determined that the services did not meet its inpatient criteria.

Policy and Billing Instructions:

In cases where a hospital utilization review committee determines that an inpatient admission does not meet the hospital's inpatient criteria, the hospital may change the beneficiary's status from inpatient to outpatient and submit an outpatient claim (TOBs 13x, 85x) for medically necessary Medicare Part B services that were furnished to the beneficiary, provided all of the following conditions are met:

1. The change in patient status from inpatient to outpatient is made prior to discharge or release, while the beneficiary is still a patient of the hospital;

2. The hospital has not submitted a claim to Medicare for the inpatient admission;

3. A physician concurs with the utilization review committee's decision; and

4. The physician's concurrence with the utilization review committee's decision is documented in the patient's medical record.

When the hospital has determined that it may submit an outpatient claim according to the conditions described above, the entire episode of care should be treated as though the inpatient admission never occurred and should be billed as an outpatient episode of care.

Refer to Pub. 100-04, Medicare Claims Processing Manual; Chapter 30, Financial Liability Protections; Section 20, Limitation On Liability (LOL) Under §1879 Where Medicare Claims Are Disallowed; for information regarding financial liability protections.

When the hospital submits a 13x or 85x bill for services furnished to a beneficiary whose status was changed from inpatient to outpatient, the hospital is required to report Condition Code 44 on the outpatient claim. Condition Code 44 will not affect payment. It will be used for monitoring purposes only to allow CMS and Quality Improvement Organizations (QIOs), to track and monitor these occurrences. Information regarding the form locator numbers that correspond to the condition codes and a table to crosswalk UB-04 form locators to the 837 transaction is found in Chapter 25.

60 – Provider Billing of Noncovered Charges to Fiscal Intermediaries

(Rev. 332, Issued: 10-22-04, Effective: 04-01-05, Implementation: 04-04-05)

60.1 - General Information on Institutional Noncovered Charges on Institutional Claims

(Rev. 332, Issued: 10-22-04, Effective: 04-01-05, Implementation: 04-04-05)

Both covered and noncovered charges can appear on Medicare claims. Since claims are submitted for payment unless otherwise noted, noncovered charges only appear/are necessary on claims. Therefore other transactions using the claim form, not seeking payment, are not affected by noncovered charge instructions (i.e., Requests for Anticipated Payment (RAPs) for home health, Notice of Election (NOEs) for hospice).

Though payment is not requested when charges are billed as noncovered, notice requirements exist establishing payment liability between the beneficiary and provider for services that are noncovered under Medicare. Liability notices, such as the Part B ABN and other similar notices, only serve to ensure that providers can shift liability under §1862(a)(1) and §1879 of the Social Security Act (the Act) when billing for services delivered to Medicare beneficiaries, that are usually covered as part of established Medicare benefits, but are thought not to be covered for a specific reason stipulated in the ABN. Denials can relate to services not being reasonable and necessary under §1862(a)(1) of the Act, §1862(a)(9) for custodial care, §1879(g)(1) for home care given to a beneficiary who is not homebound or intermittent, or §1879(g)(2) hospice care given to someone not terminally ill.

60.1.1 - Notification Requirements Related to Noncovered Charges Prior to Billing

(Rev. 332, Issued: 10-22-04, Effective: 04-01-05, Implementation: 04-04-05)

A. Payment Liability Conditions of Billing:

Before delivering any service, providers must decide which one of the following three conditions apply in order to properly inform Medicare beneficiaries as to their potential liability for payment according to notice requirements explained below:

TABLE 1:

CONDITION 1	CONDITION 2	CONDITION 3
Services are statutory exclusions (ex., not defined as part of a specific Medicare benefit) and billed as noncovered, or billed as noncovered for another specific reason not related to §1862(a)(1) and §1879 of the Act (see below)	A reduction or termination in previously covered care, or a determination of coverage related to §1862(a)(1), §1862(a)(9), §1879(g)(1) or §1879(g)(2) will require a liability notice (i.e., ABN) OR a beneficiary requests a Medicare determination be given for a service that MAY be noncovered; billing of services varies	Services billed as covered are neither statutorily excluded nor require a liability notice be given
Potential liability: Beneficiary, as services are always submitted as noncovered and therefore always denied by Medicare	Potential liability: Beneficiary, subject to Medicare determination, on claim: If a service is found to be covered, the Medicare program pays	Potential liability: Medicare, unless service is denied as part of determination on claim, in which case liability may rest with the beneficiary or provider

NOTE: Only one of these conditions can apply to a given service.

Billing follows the determination of the liability condition and notification of the beneficiary (if applicable based on the condition). To the extent possible in billing, providers should split claims so that one of these three conditions holds true for all services billed on a claim, and therefore no more than one type of beneficiary notice on liability applies to a single claim. This approach should improve understanding of potential liability for all parties and speed processing of the majority of claims.

EXCEPTION: Cases may occur where multiple conditions may apply and multiple notices could be necessary. These are most likely to occur with claims paid under the outpatient prospective payment system (OPPS, §170 of Chapter 4 of this manual), or the use of certain occurrence span codes on inpatient claims. The OPPS requires all services provided on the same day to be billed on the same claim, with few exceptions as already given in OPPS instructions (i.e.; claims using condition codes 21, 20, discussed below, or G0). Modifiers used to differentiate line items on single claims when multiple conditions or notices apply are discussed below.

Liability is determined between providers and beneficiaries when Medicare makes a payment determination by denying a service. Determinations must always be made on items submitted as noncovered (i.e., properly submitted noncovered charges are denied). These denials have appeal rights, such as any other denials. However, appeals rights in these cases are not expected to be used frequently since submitting services as noncovered should indicate agreement of the

beneficiary and provider that there is no expected Medicare payment and therefore no amount in dispute.

A rejection or "return to provider" (RTP) does not represent a payment determination. However, beneficiaries cannot be held liable for services that are never properly billed to Medicare, such that a payment determination cannot be made (i.e., a payment or a denial of payment). Rejected or RTP'ed claims can be corrected and re-submitted, permitting a determination to be made after resubmission. In some cases, beneficiaries may appeal rejections, but NEVER RTP'ed claims.

The FIs/RHHIs should not advise providers to independently cancel or adjust denied claims, such as when a line submitted as noncovered is denied, especially when a medical review determination or payment group or level would be altered. Other than exceptions noted in §130, "Adjustments" in this chapter, denied claims cannot be adjusted or resubmitted, since a payment determination cannot be altered other than by reconsideration or appeal, though providers may contact their FI/RHHI in cases of billing errors (i.e., a date typing error detected after finalization). In such cases, the FI/RHHI can consult with the provider and cancel the claim in its entirety, so that the provider can then replace the cancelled claim with a new and correct original claim.

Payment Liability Condition 1. There is no required notice if beneficiaries elect to receive services that are excluded from Medicare by statute, which is understood as not being part of a Medicare benefit, or not covered for another reason that a provider can define, but that would not relate to potential denials under §§1879 and 1862 (a) (1) of the Act. However, applicable Conditions of Participation (COPs) MAY require a provider to inform a beneficiary of payment liability BEFORE delivering services not covered by Medicare, IF the provider intends to charge the beneficiary for such services. Some examples of Medicare statutory exclusions include hearing aides, most dental services, and most prescription drugs for beneficiaries with fee-for-service Medicare prior to enactment and effectiveness of a drug benefit in 2006 under the Medicare Prescription Drug, Improvement and Modernization Act of 2003.

In addition to what may be required by the COPs, providers are advised to respect Medicare beneficiaries' right to information as described in "Medicare and You" [the Medicare handbook], by alerting them to potential payment liability. If written notification of potential liability for statutory exclusions is either required or desired, an explanation and sample voluntary notice suggested for this purpose can be found at the Centers for Medicare and Medicaid Services (CMS) Web site (see Notices of Exclusions from Medicare Benefits, NEMB):

- www.cms.hhs.gov/medicare/bni/
- Chapter 30 of this manual, Financial Liability Protections, §90

When such a notice is given, patient records should be documented. If existing, any other situations in which a patient is informed a service is not covered, should also be documented, making clear the specific reason the beneficiary was told a service would be billed as noncovered.

Payment Liability Condition 2. Providers must supply a liability notice if services delivered to a Medicare beneficiary are to be reduced or terminated following delivery of covered care, or thought not to be covered under §1862 (a) (1) of the Act, in order to shift liability under §1879. Providers must give these notices before services are delivered for which the beneficiary may be liable. Failure to provide such notices when required means the provider will not be able to shift liability to the beneficiary.

Over time, there have been two different types of such notices, given in different settings for specific types of care:

(1) Notices of non-coverage have been given to eligible inpatients receiving or previously eligible for non-hospice services covered under Medicare Part A (types of bill (TOB) 11x, 18x, 21x, and 41x) but services at issue no longer meet coverage guidelines, such as for exceeding the number of covered days in a spell of illness. In hospitals, these notices are known as Hospital Issued Notice of Non-coverage (HINNs) or hospital notices of non-coverage, in Skilled Nursing Facilities (SNFs), they may be known as Sarrassat notices. Providers have flexibility in delivering this notice: current CMS policy on such notices and comparable forms can be found at:

- Chapter 3 (Inpatient Hospital), §130.5, of the MCPM (these notices have been called HINNs);
- Chapter 30 of the Medicare Claims Processing Manual, §70-80.

NOTE: Medicare instructions are accessible at the following Web site: www.cms.hhs.gov/manuals/

(2) Outpatient ABNs, including HHABNs, are specific forms required by Medicare for providers to give to beneficiaries when: (a) Overall medical necessity of a recognized Medicare benefit is in doubt, under §1879 and §1862 (a) (1) of the Act, or (b) Care that was previously covered is to be reduced or terminated, usually because medical necessity for the service is doubted by the provider, or (c) The setting is inpatient such that other hospital and SNF specific forms are not applicable: Outpatient or Part B ABNs are used for certain Part B services -- including Part B SNF, HHA not under a plan of care, CORF and outpatient hospital, or (d) hospice services ONLY among FI-billed services paid under Part A. Current Part B - Outpatient ABN forms and instructions can be found on the CMS Web site on the ABN home page at:

- www.cms.hhs.gov/medicare/bni
- Chapter 30 of the Medicare Claims Processing Manual, §40-50 (§60 is specific to the HHABN).

Payment Liability Condition 3. This condition is the case in which providers are billing for what they believe to be covered services as covered services. There are no notice requirements just for this condition, and noncovered charges are not involved. However, as mentioned before, there are cases in which covered and noncovered charges are submitted on the same claim.

B. Summary of Notices by Provider Type:

TABLE 2:

CONDITION	Notice	Type of Provider
Payment Liability Condition 1	No notice requirement—unless COPs require--not covered for reasons other than statute, §§1862(a)(1) and 1879 of the Act do not apply - documenting records recommended	All providers
Payment Liability Condition 1	Optional notice of services excluded by statute (ex., not part of a recognized Medicare benefit, may use NEMB, Form CMS-20007)	All providers when service known not to be covered by law by the Medicare fee-for-service program
Payment Liability Condition 2	Notice of Non-Coverage or comparable form	Inpatient only (TOBs: 11x, 18x, 21x, 41x)
Payment Liability Condition 2	HHABNs (Form CMS-R-296)	Home Health (HH) services under a HH plan of care and paid through the HH prospective payment system (PPS) only (TOBs 32x and 33X)
Payment Liability Condition 2	ABNs (Form CMS-R-131-L)*	Laboratories or providers billing lab tests only (revenue codes 30x, 31x and 92x)
Payment Liability Condition 2	ABN (Form CMS-R-131-G), CMS Form 10055 for SNF Part B services ONLY	All other providers and services, outpatient and inpatient Part B, not previously listed in this chart for Condition 2, that bill FIs or RHHIs, including HH services not under a plan of care, and hospice services paid under Part A
Payment Liability Condition 3	No notice requirement	All providers

* Use of this version of the form is optional. Providers delivering same-day lab and non-lab services related to an ABN may use CMS-R-131-G for both.

60.1.2 - Services Excluded by Statute

(Rev. 133, 04-02-04)

Medicare will not pay for services excluded by statute, which often are services not recognized as part of a covered Medicare benefit. Examples of such services are given to beneficiaries in the "Medicare and You" handbook, at the end of the "Part A/Part B Cost and Coverage" subsection under Section 4 on the "Original Medicare Plan". Such services cannot necessarily be recognized in the definition of a specific procedure or diagnosis code. For example, under some conditions, a given code may be covered as part of a given benefit, but under other cases when no benefit is applied, the same code would not be covered. For claims submitted to FIs/RHHIs, these services may be: (1) Not submitted to Medicare at all, (2) Submitted as noncovered line items, or (3) Submitted on entirely noncovered claims.

A. Medicare does not require procedures excluded by statute to be billed on institutional claims submitted to FIs/RHHIs UNLESS: Medicare does not require procedures excluded by statute be billed unless: (1) Established policy requires either all services in a certain period, covered or noncovered, be billed together so that all such services can be bundled for payment consideration (i.e., procedures provided on the same day to beneficiaries under OPPS), or billing is required for reasons other than payment (i.e., utilization chargeable in inpatient settings); or (2) A beneficiary requests Medicare be billed in a manner that the service in question will be reviewed by Medicare (more on demand billing in §60.3 in this chapter).

B. To submit a noncovered line item on a claim with other covered services (Payment Liability Conditions 1 and 3), use the modifier –GY on all line items for statutory exclusions. Submit all charges for those item(s) as noncovered charges, and otherwise complete the claim as is appropriate for the covered charges. More information is given on the –GY modifier (see §60.4.2 in this chapter). This option should only be used when providers are unable to split noncovered services onto a separate claim ((3) below).

C. To submit statutory exclusions on entirely noncovered claims (Payment Liability Condition 1 only), use condition code 21, a claim-level code, signifying <u>all</u> charges that are submitted on that claim are noncovered charges. No –GY modifiers need be attached to any of the procedure codes on such a claim, and all charges must be submitted as noncovered (see §60.1.3 in this chapter).

60.1.3 - Claims with Condition Code 21

(Rev. 133, 04-02-04)

Condition code 21 can be employed to indicate no payment outpatient claims are being submitted for other reasons in addition to §60.1.2. above:

- At a beneficiary's, or other insurer's, request, to obtain a denial from Medicare on any kind of noncovered charges, to facilitate payment by subsequent insurers (ex., statutory exclusions outside Medicare benefits, such as most self-administered drugs; no modifier is required to establish liability);
- With an HHABN in special cases (see Chapter 10, §60, of this manual);
- With a SNFABN in special cases (see Chapter 6, §40.7, of this manual).

A. General Billing Instructions for No Payment Claims With Condition Code 21 (Other than HH PPS).

No payment claims are sometimes referred to as "billing for denials/denial notices". In summary, instructions applicable to all bill types other than HH PPS claims are:

- Condition code 21 must be used;
- All charges must be submitted as noncovered;
- No use of modifiers signifying provider liability (see §60.4.2 this chapter);
- Frequency code 0 (zero) must be used in the third position of TOB of the claim, though the frequency codes 7 and 8 may be used when appropriate for provider-submitted claim adjustments/cancellations;
- Total charges must equal the sum of noncovered charges;

Basic required claim elements must be completed; and

- Statement dates should conform to simultaneous claims for payment, if any.

If claims do not conform to these requirements, they will be returned to providers. However, in the case of overlapping statement dates, the incoming overlapping claim using condition code 21 will be processed to completion as a rejection, with a unique reason code explaining the reason for the rejection. Providers can then correct and re-submit the claim assuming the overlap in periods was a billing error. Noncovered charges billed on these claims when not rejected will be denied, and beneficiaries will be liable. Such denials can only be overturned on appeal.

60.1.3.1 – Provider-liable Fully Noncovered Outpatient Claims

(Rev. 332, Issued: 10-22-04, Effective: 04-01-05, Implementation: 04-04-05)

Originally with the creation of the ability of outpatient institutional providers to submit noncovered charges, only two types of fully noncovered claims were permitted: (1) No payment claims using condition code 21, or (2) Demand bills (see 60.3 below in this chapter). However, based on input from both FIs and providers, CMS subsequently recognized the need for entirely noncovered claims that could be assured to be provider-liability, since no payment claims with condition code 21 are never provider liable, and liable on demand bills cannot be assured until after review/adjudication by Medicare. A primary example of this need is a case in which a provider has failed to provide an ABN when required, and chooses to accept all liability for such services billed as noncovered.

Therefore, entirely noncovered outpatient claims are also allowed when billed with all noncovered charges, as long as either: (1) There are no indicators of liability on the claim at the claim or line level (the shared system will default in this case to holding providers liable on all denied line items); or (2) All indicators at the claim or line level indicate provider, not beneficiary, liability. An example of such an indicator is the -GZ modifier, which is often used in the case where a provider fails to give an ABN (see 60.4.2 below in this chapter). In both cases, these line items, all submitted as noncovered, will be denied.

60.1.4 - Summary of All Types of Institutional No Payment Claims

(Rev. 332, Issued: 10-22-04, Effective: 04-01-05, Implementation: 04-04-05)

Entirely noncovered inpatient claims submitted to Medicare often use frequency code 0 (zero), unless: (1) “7” for adjustments or “8” for cancellations are applicable, or (2) “traditional” condition code 20 demand bills applies, or (3) condition code 21 applies. All outpatient, inpatient Part B and hospice TOBs must use either condition code 20 or 21, or be submitted as totally noncovered without any indicators of liability or with only indicators designating provider liability, if claims are submitted as entirely noncovered.

TABLE 3:

Noncovered Indicator for Entire Claim	Table 1 Payment Liability Condition/Notice Requirements	Charges/Provider	Outcome/Liability
Frequency Code 0 on Inpatient Hospital, Swing Bed, RNHCI or SNF Claims	Condition 1 – Noncovered claim for which provider is liable, NO notice requirement **OR** Condition 1 - Updating utilization of an inpatient benefit with a claim **AND** Condition 2 - Notice of non-coverage or equivalent form	All charges submitted as noncovered; use only for inpatient Part A services (i.e., TOB 11x, 18x, 21x, 41x)	Medicare will deny all services on such bills; provider or beneficiary liable, but the beneficiary must be given a notice of non-coverage before being held liable*
Condition Code 21 with Frequency Codes 7, 8, 0 (for entire noncovered claim)	Condition 1 – Voluntary notice of statutory exclusion OR any beneficiary or other payer requested billing for denial/no payment claim when no notice requirement exists (i.e., §1862(a)(1) or §1879 of the Act do not apply) OR Condition 2 – HHABN or SNFABN, Option A on form, custodial care only	All charges for all line items on claims using this code must be submitted as noncovered, all providers can submit**	Medicare will deny all services on these claims in all cases and will hold beneficiary liable for payment on these denials
Condition Code 20 on finalized Claims with applicable Frequency Code***, or Frequency	Condition 2 – HHABN for other than custodial care OR beneficiary-requested demand billing when neither HHABN nor other type of ABN required	All traditional demand–billed charges must be submitted as noncovered, but other covered services may be submitted on the same claim for the	Medicare will suspend all claims submitted with this code, services may or may not be reviewed, properly informed beneficiaries may be liable for services

Code 7 or 9 on some HH PPS Demand Bills***		same interval by all providers	denied after suspense/ review
Provider-liable Outpatient Bills	Condition 1 – No notice requirement	All charges submitted as noncovered; use only for outpatient services (see 60.4 in this chapter)	Medicare will deny all services on such bills as provider liable

* Medicare only requires the beneficiary receive a notice if the denial is based on Condition 2.

** Noncovered claims can only be submitted for OPPS for days where no covered services are provided that same day.

*** Different frequency codes can be used with condition code 20 demand billing, however, entirely noncovered condition code 20 initial demand bills must use frequency code 0 or be HH PPS demand bills; HH PPS demand bills with frequency code 9 may be partially or entirely noncovered.

NOTE: For information on Condition Code 20 bills, see §60.3 in this chapter.

NOTE: Other than in Part A inpatient cases (TOBs 11x, 18x, 21x, and 41x), providers can submit no payment claims using condition code 21 simultaneously with claims for covered charges for the same beneficiary (i.e., split billing of covered and noncovered charges). However, such "simultaneous" claims should not contain any future dates in their statement periods (i.e., from and through dates), and noncovered claims should fit within or be equal to the statement period of simultaneous for payment claims (i.e., not overlap the statement periods of multiple claims). This is because, though unusual, no payment claims may still be appealed, potentially overturned on appeal, and no more than one claim/statement period should be subject to change if this occurs. This is particularly important for claims paid prospectively (i.e., HH PPS). All submitted noncovered or no payment claims using condition code 21 will be processed to completion, and all services on those claims, since they are submitted as noncovered, will be denied. The default liability for payment of these claims is assigned to the beneficiary, who may then submit the denial from Medicare, as the primary payer, to subsequent payer(s) for consideration. Since a denial is a Medicare determination of payment, all services submitted on no payment claims may be appealed later if unusual circumstances so warrant. That is, all payment determinations are subject to appeal, even denials of services submitted as noncovered.

60.1.5 - General Operational Information on Institutional Noncovered Charges

(Rev. 332, Issued: 10-22-04, Effective: 04-01-05, Implementation: 04-04-05)

A. Processing of Noncovered Charges in Medicare Claims Processing Systems

Questions have been raised as to whether noncovered charges are subject to all the same software modules and edits in processing as covered charges. The answer is no, but processing varies depending on how the noncovered charge is submitted.

Medicare uses code editors to assure policy requirements are met in processing claims. These requirements are expressed as edits in software reviewing procedural and diagnostic coding. The

Medicare Code Editor (MCE) is a module used on inpatient claims, and the Outpatient Code Editor (OCE) is used on outpatient claims. Entirely noncovered claims are not processed through OCE, though noncovered charges on claims with covered charges will process through these modules. However, entirely noncovered demand bills using condition code 20 may ultimately be submitted to these modules after review if some charges are judged covered.

There are 2 versions of the OCE, and most outpatient claims for various Medicare benefits flow through the OPPS OCE, not just OPPS claims. The OPPS OCE has two different edits that are applied to noncovered charges on claims with some covered charges (Edits 9 and 50). However, several OCE indicators may be applied to noncovered charges, and therefore there is no one-to-one correspondence of these indicators to specific scenarios for submission of noncovered charges, even statutory exclusions. These noncovered charges will be flagged for denial at this point or in subsequent processing.

Shared systems, also called standard systems, software forms the backbone of Medicare claims processing for Medicare institutional services. These systems link components of processing, such as code editors, Pricers, CWF, PS&R and the back-end remittance and MSN notices, and contain their own edits to assure accurate processing. Duplicate edits look for simultaneous services or claims submitted by the same provider for the same beneficiary. Entirely noncovered claims and line items, except condition code 20 demand bills, are not subject to these duplicate edits. Condition code 20 demand bills must be subject to these edits, since some services may be judged covered upon review.

Pricer software calculates the payment Medicare will make on a claim for many of Medicare's payment systems (i.e., OPPS). Neither entirely noncovered claims, nor noncovered line items, are processed through Pricer software.

The CWF is the segment of Medicare claims processing where several aspects of policy required for payment relative to a specific beneficiary are verified. For example, lifetime reserve days must be tracked for a beneficiary no matter what FI is involved in processing claims using these days. The CWF also has it own consistency edits to assure accurate payment and processing. The CWF consistency edits will not be applied to entirely noncovered claims and line items unless these edits address the validity of required claim elements (i.e., HIC number, provider number). The CWF Part B duplicate edits will also NOT be applied to entirely noncovered outpatient claims and line items, unless the claims has completely redundant data of another claim, including the same ICN (internal control number). Noncovered outpatient claims and line items subject to utilization edits or A/B crossover edits will also be bypassed. However, utilization edits will not be bypassed when they either serve to apply hospice claims to hospice periods, or to confirm beneficiary entitlement for Medicare (i.e., if not entitled to Medicare, no need to edit for noncovered charges under Medicare).

Claims or lines rejected as a duplicate PAYMENT not currently sent to CWF do not need to be sent because of noncovered charges if fitting into the following categories:

- CWF and FI duplicates;
- CWF rejects for entitlement;
- CWF rejects for claims that overlap risk HMO periods;
- CWF rejects for hospice election periods; and
- CWF rejects for HH PPS Claims that overlap other HH PPS episodes.

The outpatient CWF records (HUOP and HUHH) have been expanded to create a noncovered revenue line field to accept and pass noncovered 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.

Claims with noncovered charges, other than the rejects listed above and submitted by providers or resulting from FI review or medical review (MR) must be forwarded to CWF with the appropriate American National Standards Committee, Accredited Standards Committee X12 (ANSI ASC X12) group, adjustment reason codes, as presented in Table 9 below and elsewhere in this instruction. This must be done for both noncovered charges and covered charges on otherwise covered claims, and entirely noncovered claims. FI shared systems must provide a complete CWF input record for these claims, totaling the charges on the CWF input under revenue code 0001 (covered and noncovered). When claims are totally noncovered (TOB = XX0, condition code 21 claims, entirely provider-liable noncovered outpatient claims or some demand bills with condition code 20), the reasons for non-coverage are shown on the 0001 line. Currently, Medicare systems are limited to carrying no more than four ANSI ASC X12 reason codes per line. If the services on a claim are noncovered for multiple reasons requiring more than four codes, report the first four codes appearing on the claim on the 0001 line.

Both the shared systems and CWF react to CMS-created non-payment codes on entirely noncovered claims. 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.

Other than the distinct codes used for Medicare Secondary Payer (MSP) cost-avoided claims, entirely noncovered outpatient claims use either a “N” or “R” no payment or “no-pay” code. The N and the R no-pay codes are defined in §60.5 in this chapter. These codes do not in themselves establish payment liability. The codes function more to relay how interacting parts of Medicare systems should process and account for entirely noncovered claims; for example, with regard to tracking Medicare savings or utilization.

Generally, The R code should be used instead of the N code in all cases where a spell of illness must be updated. The HH spell of illness must be updated when processing noncovered HH PPS claims in certain situations. Accordingly, the shared systems must update home health value codes 62-65 when the R code is used, filling the values associated with the codes as zeros, since these value codes are needed to effectuate information related to the A-B Shift in the home health spell. CWF consistency edits related to the R no payment code will be bypassed in these cases. The CWF will update the dates of earliest and latest billing activity (DOEBA and DOLBA) for the benefit period, but not for the episode.

After processing is complete, remittance notices, in the electronic 835 remittance format, or standard paper format, are used to explain to providers the difference between the charges they submitted and what Medicare paid. The MSN is used to inform beneficiaries about payment for the services they received. Questions have been asked as to what remittance or MSN messages should be used for submitted noncovered charges that are denied. Unless more specific applicable requirements already exist, the following remittance and MSN messages can be used for denied noncovered charges.

TABLE 4:

Liability	Remittance Requirement	MSN Message
Beneficiary	Group code PR for patient responsibility, reason code 96 for noncovered charges	16.10 "Medicare does not pay for this item or service."; OR, "Medicare no paga por este artículo o servicio."
Provider	Group Code CO for contractual obligation, reason code 96 for noncovered charges	16.58 "The provider billed this charge as noncovered. You do not have to pay this amount."; OR, "El proveedor facuró este cargo como no cubierto. Usted no tiene que pagar ests cantidad."

60.2 - Noncovered Charges on Inpatient Bills

(Rev. 133, 04-02-04)

No Payment Inpatient Hospital and SNF Claims. Where stays begin with a noncovered level of care and end with a covered level, only one claim is required for both the noncovered and covered period, which must be billed in keeping with other billing frequency guidance (i.e., SNFs are required to bill monthly). However, SNFs and inpatient hospitals are required to submit discharge bills in cases of no payment. These bills must correctly reflect provider and beneficiary liability (see Chapter 6, §40.6.4 of this manual)

For SNFs, provider-liable no payment bills should be submitted before discharge in order to assure utilization chargeable periods are clearly posted.

For inpatient hospital PPS claims that cannot be split into covered and noncovered periods, hospital providers can submit occurrence span code 77 for provider-liable noncovered periods, and occurrence span code 76 for beneficiary-liable noncovered periods.

These procedures must be followed for Part A inpatient services (TOBs: 11x (hospital), 18x (swing bed), 21x (SNF), 41x (religious non-medical health care institutions—RNHCI)), but are not required for inpatient Part B. These no payment bills contain:

All charges submitted as noncovered;

- Frequency code 0 (zero) to be used in the third position of the type of bill

  (TOB) form locator of the original claim (i.e., not adjustment or cancellation) [NOTE: If providers do not submit no payment claims with this frequency code, the standard systems may already act to change the frequency code to 0 or return the claim to the provider];

Total charges equal the sum of noncovered charges;

Basic required claim elements must be completed;

Note units are not required when reporting noncovered days on SNF and

Inpatient Rehabilitation claims using Health Insurance Prospective Payment.

Note units are not required when reporting noncovered days on SNF and Inpatient Rehabilitation claims using Health Insurance Prospective Payment Systems (HIPPS) codes.

Claims that do not conform to these requirements will be returned to providers. For SNFs, occurrence code 22 should also be used on no payment claims when SNF care is reduced to a noncovered level and benefits had previously been exhausted. This instruction is consistent with §40.7, Chapter 6 (Inpatient SNF) in this manual.

Current instructions for inpatient no payment claims are found in the following locations:

- §40.7, Chapter 6 (Inpatient SNF), in this manual; and
- §40.4, Chapter 3 (Inpatient Hospital), in this manual.

For discussion of new and existing demand bills, which may be entirely noncovered, or contain some noncovered charges, see §60.3 immediately below.

60.3 – Noncovered Charges on Institutional Demand Bills

(Rev. 332, Issued: 10-22-04, Effective: 04-01-05, Implementation: 04-04-05)

60.3.1 - Traditional Institutional Demand Bills (Condition Code 20)

(Rev. 332, Issued: 10-22-04, Effective: 04-01-05, Implementation: 04-04-05)

Traditional demand bills, a term being coined here to encompass the only billing option existing for demand bills before the ABN with outpatient billing, use condition code 20 to indicate a beneficiary has requested billing for a service, even though the provider of the service has advised the beneficiary Medicare is not likely to pay for this service. That is, there is some dispute as to whether a service is covered or not, because if there is no dispute, billing a no payment claim or other options for noncovered charges may be more appropriate.

In the past, traditional demand billing was not always consistent or used by all providers. There was no notice requirement. Past instructions required 100 percent of specific types of demand bills to be suspended for manual review (inpatient SNF/home health, TOBs 21x, 32x , 33x), and required the provider to submit additional documentation for development to determine the medical justification for the service(s) in question.

First, if an ABN is given, special billing requirements apply (see §60.4.1 in this chapter), and traditional demand billing should NOT be used. But now, only in cases when the ABN is NOT given, services for which coverage is questioned are submitted as noncovered using traditional demand billing. This process is now open to all provider types, inpatient, and outpatient. The case of demand billing with the HHABN, opposed to the ABN, is discussed under A. “Existing Demand Billing Instructions”, immediately below.

Even though there are no notice requirements with these demand bills, providers are always encouraged to advise beneficiaries when they may be liable for payment before delivering such services, and may be required to do so by applicable COPs. In such cases, providers should also document their records that such advice has been given.

General to all demand billing, use of defective HHABNs and ABNs to effect abusive demand billing is not permitted, since current ABN/HHABN policy states routine use of these forms is

not acceptable (see §60.4.4.2, Chapter 30 (Limitation of Liability -Financial Liability Protections), of this manual). Routine use is defined in current ABN policy, and applies to all ABN forms (i.e., HHABN). If FIs/RHHIs find providers are making such use of the ABN or HHABN, they should first attempt to educate the provider. If the misuse continues, the FI/RHHI should expedite review in all subsequent cases and find the provider liable for all demand billed charges where routine use is made of the ABN or HHABN. Also in such cases, providers cannot retain any funds collected from the beneficiary in advance of a medical review decision on liability on a demand bill once a decision is made the beneficiary is not liable.

Demand billing is resource intensive for the Medicare program, and affects the timeliness of payment determinations, which should prevent conscientious providers from abusing this mechanism when there is no true doubt as to coverage/payment. Routine billing of covered services, or billing of noncovered charges as described in §60 of this chapter, should be used as appropriate when coverage/payment is not believed to be in doubt. The ABNs and HHABN are not needed in these two cases if a triggering event does not occur. Beneficiaries retain appeal rights when these other billing mechanisms are used.

A. Previously Existing Demand Bill Instructions

The CMS currently requires review and development of 100 percent of HH (TOBs 32x, 33x) and Part A SNF demand bills (TOB 21x).

1. HH PPS. There are special instructions for HH PPS demand bills. Such special instructions must be followed if: (a) An HHABN is required, or (b) If a beneficiary requests demand billing when receiving care from a home health agency (HHA) in an HH PPS episode. Instructions for such bills can be found at:

- §50 of Chapter 10 (Home Health) of the Medicare Claims Processing Manual; and
- Note these HH PPS demand bills use frequency code 9.

Note new exceptions for use of home health no payment bills in place of demand bills are described in Chapter 10, §60, of this manual.

2. SNF Demand Bills. There are special instructions for inpatient Part A SNF demand bills, which can be found at:

- Chapter 6 (Inpatient SNF), §40.7, of this manual, including use of no payment bill for custodial care; and

See also Chapter 30, §70 for Part B and General SNF ABN rules that may relate to SNF demand bills.

Previous instructions may not have been precise with regard to timing of funds collected for SNF inpatient demand bills. In order to adhere to current policy in this chapter, §30.1.1, SNFs can only collect payment for noncovered charges billed on traditional demand bills when the beneficiary who received services is technically ineligible for Part A coverage. When a Part A inpatient is involved, the SNF may not collect funds until the intermediary has made a payment determination. This restriction is an exception to all other demand billing situations, where funds may be collected from beneficiaries in advance of the determination of liability resulting from medical review of a demand bill. If the result of such review is the beneficiary is not liable, any funds collected in advance must be returned.

60.3.2 - General Demand Billing Instructions, Inpatient and Outpatient (Other than HH PPS and Part A SNF)

(Rev. 1169, Issued: 02-02-07, Effective: 07-01-07, Implementation: 07-02-07)

In addition to current home health and SNF requirements, all other provider types, including HH service NOT paid under HH PPS (i.e., TOB 34x), AND inpatient services (TOBS 11x, 21x, 18x and 41x) are required to submit demand bills using condition code 20 when requested by beneficiaries. Traditionally, hospices are the only other category of providers that have received specific guidance from FIs/RHHIs on using this type of demand bill. FIs/RHHIs perform review of such bills, for reasons such as medical necessity, coverage and payment liability issues, although inpatient hospital bills (TOB 11x) are sent to the quality improvement organizations (QIOs), formerly the peer review organizations (PROs), for medical necessity determinations exclusively.

However, for other outpatient billing, this is ONLY in cases when an ABN is not given/not appropriate (for ABN instructions, see §60.4.1 below). Also, services that the provider is sure are noncovered, such as statutory exclusions outside a recognized Medicare benefit, should never be demand billed through this process UNLESS specifically requested by a beneficiary (i.e., the beneficiary wants a determination, not just billing for denial). Either interim bills, final bills or adjustment requests may be used to demand bill.

Other covered services may appear on these claims, but not other noncovered charges, as all noncovered charges on demand bills will be considered in dispute and in need of review. Allowing covered and noncovered services to come in on demand bills will allow all services provided in the statement covers period to be billed, though payment of the covered services will be delayed by the review and development of the noncovered charges. For this reason, providers should break out demand billed services to separate claims for discrete time periods with all noncovered charges whenever possible. Such claims must contain at least one noncovered charge at issue when they are received from the provider, or the claims with condition code 20 will be returned to the provider.

Funds may be collected from beneficiaries in advance of the determination of liability resulting from medical review of a demand bill (note exception for SNFs in §60.3.1.b immediately above). If the result of such review is that the beneficiary is not liable, as when Medicare pays covered charges, any funds collected in advance must be returned.

Additionally, providers may not collect funds from beneficiaries or subsequent insurers for services for which they know they will be found liable. That is, demand billing cannot be used as a red herring to hold or retain either beneficiary or subsequent insurer funds for any period of time when the provider has reason to know they are fully liable for the services in question.

In summary, other general requirements for demand bills, other than SNF and HH PPS demand bill exceptions, are:

- Condition code 20 must be used;

- All charges associated with condition code 20 must be submitted as noncovered, all noncovered services on the demand bill must be in dispute, and at least one noncovered line must appear on the claim, but unrelated covered charges must be allowed on the same claim (unrelated noncovered charges not in dispute, if any, would be billed on a no payment claim using condition code 21 for outpatient bill types—see III. B. above);

- Frequency code zero should be used if all services on the claim are noncovered;

- Conditions codes 20 and 32 (i.e., ABN) are NEVER submitted on the same claim; and

- Basic required claim elements must be completed.

Claims not meeting these requirements will be returned to providers. Unlike entirely noncovered outpatient claims using condition code 21, no claims may be submitted simultaneously with demand bills, EXCEPT no payment claims for outpatient bill types using condition code 21, with statement period equal to or fitting within the demand bill statement period. This is true even if only charges associated with the condition code 20 are submitted on the claim, and therefore it is an entirely noncovered claim. No payment bills using condition code 21 are only used for services that are not in dispute, as opposed to noncovered charges on demand bills. This restriction is required because some services on demand bills may be found covered upon review, unlike no payment claims where there is no expectation of coverage/payment. Avoiding overlaps with other than entirely no payment claims will also prevent rejection as duplicates. If received, the incoming overlapping claim using condition code 20 will be processed to completion as a rejection, with a unique reason code explaining the reason for the rejection. Providers can then correct and re-submit the claim assuming the overlap in periods was a billing error.

Also new with this instruction, providers should be aware CMS may require development of any noncovered charge on traditional demand bills. In addition to this review, such services will then be paid, RTP'ed, rejected or denied in accordance with other instructions/edits applied in processing to completion.

60.3.3 - Summary of Methods for Institutional Demand Billing

(Rev. 332, Issued: 10-22-04, Effective: 04-01-05, Implementation: 04-04-05)

Providers must decide which condition and notice requirement is appropriate to the billing situation, and use only one of these options in each case, as follows:

TABLE 5:

Situation and Notice Requirement	Description/Charges	Applicable Providers
No ABN or HHABN required, beneficiary not in a HH PPS episode, beneficiary in SNFPPS episode or otherwise	Claims use condition code 20, and submit charges in question as noncovered in accordance with demand billing instructions	All outpatient/ hospice/inpatient providers except HHAs paid under HH PPS (i.e., all types of

requests a demand bill be submitted (i.e., for a service excluded by statute)		bill (TOB) submitted to FIs/RHHIs EXCEPT 32x and 33x)
HHABN required OR service must be demand billed at beneficiary request during an HH PPS episode	Claims use condition code 20, and submit charges in question as noncovered according to directions for HH PPS demand bills	Only HHAs paid under HH PPS (TOB 32x and 33x only, frequency code 9)
Part B ABN required (i.e., 131-L --lab services only; 131-G)* **NOTE:** Modifiers required when services not related to ABN must be billed on same claim	Claims use occurrence code 32, report the date the ABN was signed, and all services related to the ABN are submitted as covered charges	All outpatient/ hospice/inpatient Part B providers EXCEPT HHAs paid under HH PPS (i.e., all TOBs submitted to FIs/RHHIs except TOB 32x and 33x)

- Use of this version of the form is optional. Providers delivering same-day lab and non-lab services related to an ABN may use CMS-R-131-G for both.

Same-day billing requirements under OPPS present a particular challenge. If a case occurred in which a OPPS hospital provided two services thought to be noncovered and in dispute on the same day, one for which an ABN was given and one without an ABN, the services would have to be submitted on two separate claims. One of these claims would be a demand bill using condition code 20 for the service not associated with the ABN, the other one a claim using occurrence code 32, which would contain the service associated with the ABN billed as covered, and could also contain other covered services provided that day (see Section III. H. below on the use of the –GA modifier). Both claims should process to completion, unless other edits apply, since claims using condition code 20 have always been exempted from the OPPS same day billing rule.

60.4 - Noncovered Charges on Outpatient Bills

(Rev. 1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

The term “outpatient” is often used very generally. In this section, the term should be applied to benefits that are both: (1) Not exclusively inpatient, and (2) Not Part A TOBs (i.e., not TOBs 11x, 18x, 21x, 41x). Therefore, “outpatient” here includes inpatient Part B (TOBs 12x, 22x) and hospice (TOBs 81x, 82x).

TABLE 6:

Definition of Fee-for-Service (Traditional or Original) Medicare Inpatient and Outpatient Services by Bill Type

Concise/General Policy Description: An inpatient service requires a beneficiary reside in a specific institutional setting during treatment. An outpatient service is provided by an

institutional provider, but beneficiaries are not necessarily confined to a specific institution for periods of 24 hours or more.

Concise/General Claims/Systems Definition: The use of the category terminology is understood to reference the specific listed bill types, EXCEPT general use of the term outpatient is generally understood as all bill types EXCEPT those defined as inpatient Part A. Specific trust fund payment is associated with these bill types. Note an "x" represents a varying third digit in the bill type not needed to identify the benefit.

Category	**Medicare FFS Bill Types (All Types Listed)**	**Trust Fund Payment**
Inpatient Part A	11x – Hospital 18x – Swing Bed 21x – Skilled Nursing Facility (SNF) 41x – RNHCI – Religious Non-Medical Health Care Institution – inpatient	Part A only
Inpatient	12x – Hospital	Part B only
Part B*	22x – SNF	
In/Outpatient Part A*	81x, 82x – Hospice	Part A only
Outpatient*	13x, 14x – Hospital 23x – SNF 34x – Home Health (not prospective payment (PPS)) 43x – RNHCI outpatient 71x – RHC – Rural Health Clinic 72x – RDF – Renal Dialysis Facility 73x – FQHC – Federally Qualified Health Center 74x – ORF – Outpatient Rehabilitation Facility 75x – CORF – Comprehensive ORF 76x – CMHC – Community Mental Health Center 83x – Hospital Outpatient Surgery[1] 85x – Critical Access Hospital (CAH) = 32x, 33x – Home Health (PPS) = 89x – NOE[2] for Coordinated Care Demonstration	Part B only = = = = = = = Parts A and B = = = = = = = No payment

[1]Subject to Ambulatory Surgery Center (ASC) payment limits

- * Treated as outpatient in processing unless instructions specify otherwise. Note that for inpatient Part B claims, since 10/2003 HIPAA requires that, when transmitted, these claims conform to inpatient requirements for the institutional 837 claim transaction, though Medicare systems will still process these claims like outpatient transactions when received.

60.4.1 - Billing with an ABN (Use of Occurrence Code 32) Comparable to Traditional Demand Bills

(Rev. 133, 04-02-04)

Now, using an ABN is frequently required, much more often than traditional demand billing, usually when medical necessity for outpatient services is in doubt, or when other issues captured in §1862(a)(1) and §1879 of the Act apply, or when previous covered treatment is to be reduced or terminated within a Medicare benefit. Previous ABN instructions brought about a large change in billing practices, because before these instructions, covered charges were never billed when medical necessity was in doubt.

In using the ABN, beneficiaries select one of several billing options they prefer in the face of the provider's anticipation Medicare will not cover a service. Providers can never pre-select ABN options for beneficiaries, in accordance with existing ABN policy, nor are clarifications on billing related to the ABN in this or other chapters of this manual meant to imply ABN options can be pre-selected.

Claims billed in association with an ABN never use condition code 20 or 21, other than HHPPS and SNF PPS exceptions, and will be returned to providers if received, but instead:

Must use a claim-level occurrence code 32 to signify all services on the claim are associated with one particular ABN given on a specific date (unless the use of modifiers, discussed below, makes clear not every line on the claim is linked to the ABN);

Must provide the date the ABN was signed by the beneficiary in association with the occurrence code;

Occurrence code 32 and accompanying date must be used multiple times if more than one ABN is tied to a single claim for services that must be bundled/billed on the same claim (i.e., one date for one ABN lab services tied to a R-131-L, another for services tied to a R-131-G, even if the date is the same for both ABNs);

Must submit all ABN-related services as covered charges (note –GA modifier exception, below); and

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[2] Notice of Election, which creates a benefit period in Medicare systems (Common Working File) against which utilization or payment can be tracked; this is the only type of NOE that requires a specific character in the second digit of the bill type, aside from requirements for the frequency cod (third digit).

Must complete all basic required claim elements as for other comparable claims for covered services.

Again, if an ABN is given, these billing procedures must be used, rather than traditional demand billing. Providers should be aware CMS may require suspension of any claims using occurrence code 32 for medical review of covered charges associated with an ABN. Citations for instructions on the ABN, which include information on when an ABN is appropriate, are given above. If claims using occurrence code 32 remain covered, they will be paid, RTP'ed, rejected or denied in accordance with other instructions/edits applied in processing to completion. Denials made through automated medical review of service submitted as covered are still permitted after medical review, and the FI will determine if additional documentation requests or manual development of these services are warranted. For all denials of services associated with the ABN, the beneficiary will be liable.

The –GA modifier is used when provider must bill services related and not related to a ABN on the same claim. See §60.4.2. below for more information this modifier, but note that in the case when it is used both covered and noncovered service may appear on the ABN-related claim.

60.4.2 - Line-Item Modifiers Related to Reporting of Noncovered Charges When Covered and Noncovered Services Are on the Same Institutional Claim

(Rev. 1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

Several Healthcare Common Procedural Coding System (HCPCS) modifiers are used to signify a specific line item is either not covered or not payable by Medicare, for many different reasons. The chart immediately below lists all those modifiers, many more commonly used by Medicare carriers, for services not covered or not payable by Medicare. Modifiers not payable to carriers are also not payable to FIs/RHHIs, and will be denied if submitted on claims. Providers are liable for these denials, UNLESS a specific modifier (see second table in this section) or indicator on the claim (i.e., occurrence code 32) specifically attaches liability to the beneficiary. These modifiers, not covered or payable by definition of the national HCPCS committee, along with other modifiers affecting payment that have been brought up in discussion of noncovered charges, are presented in the following chart:

TABLE 7:

NOTE: This table does not include ambulance origin and destination modifiers, which may fall into the ranges of modifiers values below, but are NOT noncovered by definition.

Source of the Modifier List	Noncovered Modifiers	Claims Processing Instructions	Definition Source
HCPCS Modifiers Not Covered or Not Payable by Medicare by HCPCS Definition (HCPCS Administrative Instruction)	-A1 through -A9, -GY, -GZ, -H9, -HA through -HZ, -SA through -SE, -SH, -SJ, -SK, -SL, -ST, -SU, -SV, -TD through -TH, -TJ through -TN, - TP through -TW, -U1 through -U9, -UA through –UD	FI standard systems will deny all line items on all TOBs using these modifiers in all cases as part of processing claims (if not fully implemented before, all will be denied with the implementation of this instruction); provider liability is assumed EXCEPT when noted as beneficiary liable in accordance with the chart below (of the total set to the left:- GY, -TS)	Use as defined by publication of HCPCS codes by CMS
CPT/HCPCS Modifiers Permitted on OPPS Claims	See current OPPS instructions subsequent to Transmittal A-02-129	FI standard systems accept these modifiers for processing on OPPS claims (TOBs: 12, 13, 14) in accordance with HCPCS/CPT definitions	CPT numerical modifiers defined in publication of “CPT Manual” by the American Medical Association; HCPCS codes as defined by publication of HCPCS codes by CMS
Modifiers Used in Billing Ambulance Noncovered Charges (Transmittal A-02-113, new instructions below)	-GY, -QL, -QM* or -QN*, -TQ, alpha origin/destination modifiers*	Applicable TOBs for ambulance billing: 12x, 13x, 22x, 23x, 83x, 85x	See ambulance instructions (III. I.) and chart immediately below
Specific HCPCS Modifiers to	-EY, -GA, -GK, -GL, -GY, -GZ, -KB, -TS	FI standard systems accept some of these modifiers for	See chart immediately below

Source of the Modifier List	Noncovered Modifiers	Claims Processing Instructions	Definition Source
Consider Related to Noncovered Charges or ABNs		processing as specified on the chart below with the implementation of this instruction	

* These modifiers are not noncovered by definition, but rather are commonly used on noncovered lines

In the past, modifiers were more frequently used to qualify procedure codes submitted on professional billing formats, such as Form CMS-1500, to entities like Medicare carriers. Use of modifiers has increased in institutional billing over time, though, unlike professional claims, institutional claims did not always require the use of procedure codes in addition to revenue codes.

The Health Insurance Portability and Accountability Act (HIPAA) requires all submitters of electronic claims to use the 837 electronic format. The version of this format providers must use as of that time relates modifiers to associated procedure codes, including HCPCS. Therefore, HCPCS/procedural coding is required on any noncovered line item using one of the modifiers described in this instruction. In fact, the FI shared system will require procedure codes to be present any time a modifier is used, whether the line is covered or not.

Providers should use explicit procedure or HCPCS coding to describe services and items they deliver, even when submitting these items as noncovered. In cases in which general HCPCS coding may be needed to submit a noncovered service for which Medicare institutional claims have not required HCPCS coding in the past, such as with drugs or supplies, the following HCPCS code can be used with the appropriate revenue code in order to employ a modifier:

A9270 Noncovered item or service

The FI/RHHI systems will accept this code, which, since it is noncovered by Medicare by definition, will be denied in all cases. Liability will rest with the provider, unless a modifier is used to assign liability to the beneficiary (i.e., -GL, -GY, -TS), when the beneficiary has been informed, prior to service delivery, that he/she may be liable for payment. Note –GA of –KB cannot be used with this code since they require~~s~~ covered charges. Modifiers most likely to be used with ABNs or noncovered charges or liability notices are listed below.

TABLE 8:

Definition of Modifiers Related to Noncovered Charges/ABNs for FI/RHHI Billing

Mod-ifier	**HCPCS Modifier Definition**	**HCPCS Coverage/ Payment/Admini-strative Instruction**	**Notice Requirement/ Liability**	**Billing Use**	**Payment Result**
-EY	No Physician or Other Licensed Health Care Provider Order for this Item or Service	None	None, cannot be used when HHABN or ABN is required, recommend documenting records; liability is provider unless other modifiers are used (-GL, -GY, or –TS)	To signify a line-item should not receive payment when Medicare requires orders to support delivery of a item or service (i.e., TOBs 21x, 22x, 32x, 33x, 34x, 74x, 75x, 76x, 81x, 82x, 85x)	When orders required, line item is submitted as noncovered and services will be denied
-GA	Waiver of Liability Statement on File	None	ABN required; beneficiary liable	To signify a line item is linked to an ABN when charges both related to and not related to an ABN must be submitted on the same claim	Line item must be submitted as covered; Medicare makes a determination for payment
Mod-ifier	HCPCS Modifier Definition	HCPCS Coverage/ Payment/Admini-strative Instruction	Notice Requirement/ Liability	Billing Use	Payment Result
-GK	Actual Item/Service Ordered by a Physician, Item Associated with a –GA or –GZ modifier	None	ABN required if –GA is used; no liability assumption since this modifier should not be used on FI claims	Use –GA or –GZ modifier as appropriate instead	Claims submitted to FIs using this modifier should be returned to the provider with the implementation of this instruction

-GL	Medically Unnecessary Upgrade Provided instead of Standard Item, No Charge, No ABN	None	Can't be used if ABN/HHABN is required, COPs may require notice, recommend documenting records; beneficiary liable	Use only with durable medical equipment (DME) items billed to the RHHIs (TOBs: 32x, 33x, 34x)	Lines submitted as noncovered and will be denied
-GY	Item or Service Statutorily Excluded or Does Not Meet the Definition of Any Medicare Benefit	Noncovered by Medicare Statute (ex., service not part of recognized Medicare benefit)	Optional notice only, unless required by COPs; beneficiary liable	Use on all types of line items on provider claims	Lines submitted as noncovered and will be denied
Mod-ifier	HCPCS Modifier Definition	HCPCS Coverage/ Payment/Admini-strative Instruction	Notice Requirement/ Liability	Billing Use	Payment Result

-GZ	Item or Service Expected to Be Denied as Not Reasonable and Necessary	May be noncovered by Medicare	Cannot be used when ABN or HHABN is actually given, recommend documenting records; provider liable	Since with this instruction, condition code 20 demand bills can be submitted by all FI provider types, and these bills can accept covered and noncovered charges, and noncovered charges on these bills are already specified as requiring medical review, this modifier will not signal review is needed, but is available for optional use on demand bills NOT related to an ABN by providers who want to acknowledge they didn't provided an ABN for a specific line	Lines submitted as noncovered and will be denied
-KB	Beneficiary Requested Upgrade for ABN, more than 4 Modifiers on a Claim	None	ABN Required; if service denied in development, beneficiary assumed liable	Use only on line items requiring more than [2 or] 4* modifiers on home health DME claims (TOBs 32x, 33x, 34x)	Line item submitted as covered, claim must suspend for development *
-QL	Patient pronounced dead after ambulance called	None	None, recommend documenting records; provider liable	Use only for ambulance services (TOBs: 12x, 13x, 22x, 23x, 83x, 85x)	Mileage lines submitted as noncovered and will be denied; base rate line submitted covered

Mod - ifier	HCPCS Modifier Definition	HCPCS Coverage/ Payment/ Admini- strative Instruction	Notice Requirement/ Liability	Billing Use	Payment Result
-TQ	Basic life support by transport by a volunteer ambulance provider	Not payable by Medicare	None, recommend documenting records; provider liable	Use only for ambulance services (TOBs: 12x, 13x, 22x, 23x, 83x, 85x)	Lines submitted as noncovered and will be denied
-TS	Follow-Up Service	Not payable by Medicare	No notice requirement, unless COPs require, recommend documenting records; beneficiary liable	Use on all types of provider claims when services are billed as noncovered for reasons other than can be established with other coding/modifiers (i.e., -GY) when the beneficiary is liable for other documented reasons	Lines submitted as noncovered and will be denied

* **NOTE**: Many provider systems will not allow the submission of more than two modifiers. In such cases, despite the official definition and the capacity of the Medicare systems to take in five modifiers on a line with direct EDI submission, RHHIs should educate that it is appropriate to use this modifier when three modifiers are needed if there is a two-modifier limit]

All modifiers listed in the chart immediately above that may be submitted on noncovered line items need only be used for Medicare when noncovered services cannot be split to entirely noncovered claims; however, modifiers indicating provider liability cannot be used on entirely no payment claims for which the beneficiary has liability.

In general, inappropriate use of these modifiers may result in entire claims being returned to providers. For example, if a modifier is required to be billed on a line with covered charges, and is billed with noncovered charges, the claims will be returned.

The modifier –GA should only be used when line items related to an ABN cannot be split to a separate claim with only services related to that ABN (occurrence code 32 demand bills). Occurrence code 32 must still be used on claims using the –GA modifier, so that theses services can be linked to specific ABN(s). In such cases, only the line items using the –GA modifier are considered related to the ABN and must be covered charges, other line items on the same claims may appear as covered or noncovered charges. Both the –GA and –KB modifiers may suspend for review.

Modifier –GK should never be used on FI/RHHI claims. Claims using this modifier will be returned to providers for correction.

60.4.3 - Clarifying Institutional Instructions for Outpatient Therapies Billed as Noncovered, on Other Than HH PPS Claims, and for Critical Access Hospitals (CAHs) Billing the Same HCPCS Requiring Specific Time Increments

(Rev. 332, Issued: 10-22-04, Effective: 04-01-05, Implementation: 04-04-05)

Claims for outpatient rehabilitative services, including certain audiology services and comprehensive outpatient rehabilitative facility (CORF) services, require billing with HCPCS procedure codes and line item dates, so that proper payment can be made under the Medicare Physician Fee Schedule. Complete instructions for many provider types for such billing can be found in §10 thru 40.5, Chapter 5 (Outpatient Rehabilitation) of this manual.

Though these instructions are still current and should be followed, they did not previously discuss billing for noncovered charges. This update to those instructions allows the submission of noncovered charges. Outpatient therapies billed as noncovered charges are not counted toward the therapy cap, when in effect, unless subject to review and found to be covered by Medicare--note hospital bills are not subject to this cap. Modifiers presented in the previous section of this instruction can be used with therapies, in addition to therapy-specific instructions for the use of modifiers –GN, -GO and –GP

Critical Access Hospitals (CAHs)

Although CAHs are not addressed in §10-40.5, Chapter 5 (cited above), since they are not subject to payment on a fee basis under the Medicare Physician Fee Schedule, they sometimes bill therapies using HCPCS that by definition give specific time increments like those discussed below. Therefore, CAHs should follow the instructions below if there is a need to bill noncovered increments.

When HCPCS codes required for reporting do not specify an increment of billing in their definition (i.e., 15 minute intervals), the unit for the line item is 1, and general instructions given above for billing noncovered charges, either by the line item or on no payment claims, can be followed.

Several of the outpatient therapy HCPCS codes, however, do specify billing in specific time increments in their definition, and current instructions state units reported on line items should be consistent with these definitions. In such cases, when both covered and noncovered increments are provided in the same visit on the same date of service, billing should be done as follows:

- Use an ABN and modifiers when appropriate to explain non-coverage and payment liability of specific lines when covered and noncovered increments of the same visit appear on the same claim (i.e., -GY, see above);
- Report covered and noncovered units in separate line items, even when part of the same visit, with one line item for all covered and noncovered increments in a visit, and another for all noncovered increments in that same visit;
- Do not report noncovered line items that are part of a partially covered service on a separate no payment claim (i.e., using condition code 21); always report them on the same claim with the separate lines for the covered portion of the service, no payment

claims received for the same date, same beneficiary, same provider and same therapy service as a for-payment claims will be processed to completion and rejected. A distinct reason code will make providers aware of the reason for the rejection, and they can correct their billing to have covered and noncovered portions of the same service on the same claim;

- Services of less than 8 minutes for codes defined in 15-minute increments could be billed as a separate line item of a single noncovered unit (i.e., noncovered charges are equal to total charges, service unit is 1), BUT such billing would be contrary to clinical and coding guidelines, and therefore should not be done;
- Do not report noncovered line items as part of the required reporting of value codes 50, 51 and 52 for covered visits (i.e., where all increments are noncovered and there are no covered charges for the line item, since these line items are either part of an already counted partially covered visit, or an entirely noncovered visit); and

3. Never split a single increment into a covered and noncovered portion.

60.4.4 - New Instructions for Noncovered Charges for Mileage on Institutional Ambulance Claims

(Rev. 332, Issued: 10-22-04, Effective: 04-01-05, Implementation: 04-04-05)

Previous instructions presented one scenario in which noncovered ambulance miles would be billed: The statutory restriction that miles beyond the closest available facility cannot be billed to Medicare. This previous instruction only stated that noncovered miles beyond the closest facility had to be billed with HCPCS procedure code A0888 ("noncovered ambulance mileage per mile, e.g., for miles traveled beyond the closest appropriate facility") on an entirely noncovered claim using condition code 21. While A0888 is still used for this purpose, and existing base ambulance requirements, such as reporting HCPCS, origin/destination and zip code, still stand, otherwise instructions for reporting ambulance noncovered mileage charges are presented in this section.

There is no longer any need for providers to use any other past instruction for submitting noncovered charges, such as forcing a one-dollar amount onto a noncovered line. Use of this mechanism will result in claims being returned after October 2003. Medicare will now process actual amounts of noncovered charges, when reported as such, in all cases.

Ambulance claims may use the –GY modifier on line items for such noncovered mileage, so that such items can be billed on claims also containing covered charges, and liability be assigned correctly to the beneficiary for such line item(s). This method of billing is preferable in this specific scenario, miles beyond the closest available facility, so that all miles for the same trip, perhaps with covered and noncovered portions, can be billed on the same claim. However, billing using condition code 21 claims will continue to be permitted, if desired, as long as all line items on the claims are noncovered and the beneficiary is liable. Additionally, unless requested by the beneficiary or required by specific Medicare policy, services excluded by statute do not have to be billed to Medicare.

When the scenario is point of pick up outside the United States, including U.S. territories but excepting some points in Canada and Mexico in some cases, mileage is also statutorily excluded from Medicare coverage. However, such billings are more likely to be submitted on entirely

noncovered claims using condition code 21. Also, this scenario requires the use of a different message on the Medicare Summary Notice (MSN) sent to beneficiaries.

There is another straightforward scenario in which billing noncovered mileage to Medicare may occur. This is when the beneficiary dies after the ambulance has been called but before the ambulance arrives. The –QL modifier should be used on the base rate line in this scenario, in place of origin and destination modifiers, and is submitted with covered charges, but, with the implementation of this instruction, will also be used on the accompanying mileage line, if submitted, with noncovered charges. Submitting this noncovered mileage line is an option for providers, not a requirement, as with other outpatient noncovered charges.

The final scenario in which non-covered charges apply is if there is a subsidy of mileage charges that are never charged to Medicare. Because there are no charges for Medicare to share in, the only billing option is to submit noncovered charges, if billing is done at all (it is not required in such cases). These noncovered charges are not really charges, and therefore are unallowable, and should not be considered in settlement of cost reports. However, there is a difference in billing if such charges are subsidized, but otherwise would normally be charged to Medicare as the primary payer. In this latter case, CMS examination of existing rules relating to grants policy since October 1983, supported by federal regulations (42CFR 405.423), generally requires providers to reduce their costs by the amount of grants and gifts restricted to pay for such costs. Thereafter, section 405.423 was deleted from the regulations. Thus, providers were no longer required to reduce their costs for restricted grants and gifts, and charges tied to such grants/gifts/subsidies should be submitted as covered charges. This is in keeping with Congress's intent to encourage hospital philanthropy, allowing the provider receiving the subsidy to use it, and also requiring Medicare to share in the unreduced cost. Treatment of subsidized charges as non-covered Medicare charges serves to reduce Medicare payment on the Medicare cost report contrary to the 1983 change in policy.

Billing requirements for all these situations, including the use of modifiers, are presented in the chart below:

TABLE 9:

Mileage Scenario	HCPCS	Modifiers*	Liab-ility	Billing	Remit. Require-ments	MSN Message
STATUTE: Miles beyond closest facility, OR **Pick up point outside of U.S.	A0888 on line item for the noncovered mileage	-QM or –QN, origin/destin-ation modifier, and –GY unless condition code 21 claim used	Bene-ficiary	Bill mileage line item with A0888 –GY and other modifiers as needed to establish liability, line item will be denied; OR bill service on condition code 21 claim, no –GY required, claim will be denied	Group code PR for patient responsi-bility, reason code 96: noncovered charges	16.10 "Medicare does not pay for this item or service"; OR, "Medicare no paga por este artículo o servicio"
Beneficia	Most	–QL unless	Pro-	Bill mileage line	Group Code	16.58 "The

ry dies after ambulance is called	appropri-ate ambulance HCPCS mileage code (i.e., ground, air)	condition code –21 claim	vider	item with –QL as noncovered, line item will be denied	CO for contract-ual obligation, reason code 96 for noncovered charges	provider billed this charge as noncovered. You do not have to pay this amount."; OR, "El proveedor facuró este cargo como no cubierto. Usted no tiene que pagar ests cantidad."
Subsidy or government owned Ambulance, Medicare NEVER billed***	A0888 on line item for the noncovered mileage	-QM or –QN, origin/destin-ation modifier, and -TQ must be used for policy purposes	Pro-vider	Bill mileage line item with A0888, and modifiers as noncovered, line item will be denied	Group Code CO for contractual obligation, reason code 96 for noncovered charges	16.58 "The provider billed this charge as noncovered. You do not have to pay this amount."; OR, "El proveedor facuró este cargo como no cubierto. Usted no tiene que pagar ests cantidad."

* Current ambulance billing requirements state that either the –QM or –QN modifier must be used on services. The –QM is used when the "ambulance service is provided under arrangement by a provider of services," and the –QN when the "ambulance service is provided directly by a provider of services." Line items using either the –QM or –QN modifiers are not subject to the FISS edit associated with FISS reason code 31322 so that these lines items will process to completion. Origin/destination modifiers, also required by current instruction, combine two alpha characters: one for origin, one for destination, and are not noncovered by definition.

** This is the one scenario where the base rate is not paid in addition to mileage, and there are certain exceptions in Canada and Mexico where mileage is covered as described in existing ambulance instructions.

***If Medicare would normally have been billed, submit mileage charges as covered charges despite subsidies.

Providers not complying with the requirements in the table may have their claims returned.

The use of the –TQ modifier is required so that CMS policy can track the instances of the subsidy scenario for non-covered charges. The –TQ should be used whether the subsidizing entity is governmental or voluntary. The -TQ modifier is not required in the case of covered charges submitted when a subsidy has been made, but charges are still normally made to Medicare as the primary payer.

If providers believe they have been significantly or materially penalized in the past by the failure of their cost reports to consider covered charges occurring in the subsidy case, since Medicare had previous billing instructions that stated all charges in the case of a subsidy, not just charges

when the entity providing the subsidy never charges another entity/primary payer, should be submitted as noncovered charges, they may contact their FI about reopening the reports in question for which the time period in 42 CFR 405.1885 has not expired. FIs have the discretion to determine if the amount in question warrants reopening. The CMS does not expect many such cases to occur.

60.4.5 - Clarification of Liability for Preventive Screening Benefits Subject to Frequency Limits

(Rev. 133, 04-02-04)

Some Medicare preventive benefits are subject to frequency limits, and are also specifically cited at §1862 (a)(1) (F) ff. of the Act as subject to "medical necessity." There has been some confusion as to the basis of denial and how such services are adjudicated. When medical necessity is the basis for denial (i.e., §1862 (a)(1) (F) ff. of the Act), a ABN is necessary in order to shift the liability to the beneficiary, and special ABN-related billing must be used (see III. E. above). Services above frequency limits, however, had been erroneously considered noncovered services by some, and billed as such, not requiring ABNs. In these cases default liability in Medicare systems is the provider, unless specific billing methods and modifiers were used to signal beneficiary liability (see sections III A. and B. above).

Medicare FIs systems had been programmed with frequency as the primary reason for denial at one time, and Medicare carrier systems have used medical necessity. FI systems have changed so that medical necessity is the primary reason for denial.

It may be contrary to provider practices to submit services over the frequency limit as covered charges, as ABN billing requires. However, it can be pointed out that existing Common Working File (CWF) frequency edits should still result in the denial of these services. Remittance denial reason codes and MSN messages to be used in this situation are listed below for beneficiary and provider liability should either circumstance occur:

TABLE 10:

Preventive Benefit	HCPCS Code(s)	PROVIDER LIABLE (ANSI) Remittance Group and Reason Code	PROVIDER LIABLE MSN Message	BENE. LIABLE (ANSI) Remittance Group and Reason Code	BENE. LIABLE MSN Message
Screening mammography	G0202, 76092, 76083	CO – 57 [57: Payment denied/reduced because the payer deems the information submitted does not support this	15.21 The information provided does not support the need for this many services or items in this period of time but you do not have to pay	PR – 57* [57: Payment denied/reduced because the payer deems the information submitted does not	15.22 The information provided does not support the need for this many services or items in this period of time so Medicare

		level of service, this many services, this length of service, this dosage, or this day's supply.]	this amount. [Le informacion proporciona-da no justifica la necesidad do esta cantidad de servicios o articulos an este periodo de tiempo pero usted no tiene que pagar esta cantidad.]	support this level of service, this many services, this length of service, this dosage, or this day's supply.]	will not pay for this item or service. [Le informacion proporcio-nada no justifica la necesidad do esta cantidad de servicios o articulos an este periodo de tiempo por lo cual Medicare no pagara por este articulo o servicio.]

Preventive Benefit	**HCPCS Code(s)**	**PROVIDER LIABLE (ANSI) Remittance Group and Reason Code**	**PROVIDER LIABLE MSN Message**	**BENE. LIABLE (ANSI) Remittance Group and Reason Code**	**BENE. LIABLE MSN Message**
Screening pap smear	G0123, G0143, G0144, G0145, G0147, G0148, P3000, Q0091	CO - 57	Ditto above	PR – 57*	Ditto above
Screening pelvic exam	G0101	CO - 57	Ditto above	PR – 57*	Ditto above
Screening glaucoma	G0117, G0118	CO - 57	Ditto above	PR – 57*	Ditto above
Prostate cancer screening test	G0102, G0103	CO - 57	Ditto above	PR – 57*	Ditto above
Colorectal cancer	G0104, G0106,	CO - 57	Ditto above	PR – 57*	Ditto above

screening test	G0107, G0120, G0122				

- This ANSI ASC X12 reason code becomes obsolete with implementation of the 835 remittance version 4050. For the purpose of this table, use of 57 in the 835 version 4050 and subsequent versions can be crosswalked to code 151: "Payment adjusted because the payer deems the information submitted does not support this many services".

60.4.6 - Clarification on Notice Requirements Related to Billing Noncovered Charges for "Bundled" Institutional Benefits: Laboratory and Rural Health Clinic (RHC)/Federally Qualified Health Clinic (FQHC) Examples

(Rev. 332, Issued: 10-22-04, Effective: 04-01-05, Implementation: 04-04-05)

Some Medicare payment policies or systems group or bundle several items or services into a single unit for payment; an example is a prospective payment system that pays a pre-determined amount independent of what particular services or items may be delivered in a given period of treatment. Questions arise in such cases, in terms of notifying beneficiaries of liability and billing, when some of the services in the bundle are thought to be covered, and some are not.

Regarding notification, §50.7.7.6 of Chapter 30 of this manual states: "ABNs may not be used to shift liability to a beneficiary in the case of services or items for which full payment is bundled into other payments; that is, where the beneficiary would otherwise not be liable for payment for the service or item because bundled payment is made by Medicare. Using an ABN to collect from a beneficiary where full payment is made on a bundled basis would constitute double billing. An ABN may be used to shift liability [only]… where part of the cost is not included in the bundled payment made by Medicare." In short, an ABN has to apply to all of a bundled service, or none of it.

Billing follows notification. In terms of billing, this means all of a bundled service must be billed as noncovered, or none of it, since there is not a clear way for providers to dismantle bundled Medicare payment policies and associated billing requirements. Therefore, as long as part of a bundled service is certain to be covered or medically necessary, billing the entire bundled service as covered is appropriate. Medicare adjudication may still result in all, part or none of such services being paid, or something submitted as one type of bundled payment being re-grouped into another type of payment. If the entire bundle is certain to be non-covered, the service should be billed as noncovered. If there is overall doubt as to the medical necessity of the bundle, such as when a Medicare benefit but does not seem to be medically necessary, then rules for billing in association with an ABN (see 60.4.1 in this Chapter) or demand billing (60.3 in this chapter) would apply. This last statement is always true when necessity is in doubt relative to all services in the bundle, but may also be used if a provider is uncertain of necessity of the majority services, and feels uncomfortable billing the entire bundle as covered for a specific reason.

Two specific areas that have raised questions regarding this policy are RHC/FQHC bundled encounter payments and lab panel tests. Many different professional services can be bundled into a RHC/FQHC encounter, and these providers are not required to provide service or item-specific detail on their claims, billing the entire encounter as a single line-item. Therefore, such encounters can only be billed as entirely covered, entirely non-covered, or billed in association with an ABN or demand billed if overall coverage is in doubt. However, if the majority of services provided in an encounter were known to be covered, even if some other services in the

same encounter were thought to be noncovered though part of either the RHC or FQHC benefit, the entire bundle would be billed as covered on a single line item.

The same concept applies for lab panel tests. Medical necessity decisions are made relative to the appropriateness of the entire panel, not the individual tests comprised in the panel. However, such items may still be denied if, when considered in their entirety, the panel does not seem justified, and billing specific individuals test(s) would have been appropriate.

60.5- Intermediary Processing of No-Payment Bills

(Rev. 493, Issued: 03-04-05, Effective: 04-04-05, Implementation: 04-04-05)

Nonpayment Codes

Intermediaries use nonpayment codes in CWF records where payment is not made. (Claims where partial payment is made do not require nonpayment codes.) These codes alert CWF to bypass edits in processing that are not appropriate in nonpayment cases. Nonpayment codes also alert CWF to update a beneficiary's utilization records (deductible, spell of illness, etc.) in certain situations. While this section refers to provider or beneficiary liability, nonpayment codes themselves do not assign liability on Medicare claims.

The intermediary enters the appropriate code in the CWF record if the nonpayment situation applies to all services covered by the claim. It does not enter the nonpayment code if partial payment is made. Also, it does not enter the nonpayment code when payment is made in full by an insurer primary to Medicare. When the intermediary identifies such situations in its development or processing of the claim, it adjusts the claim data the provider submitted, and prepares an appropriate CWF record.

1. Nonpayment Code B - Benefits Exhausted Before "From" Date on Bill.

The intermediary uses code B on inpatient claims in the following instances:

- When benefits and/or lifetime reserve days are exhausted, or full days and coinsurance days are exhausted; and
- When the beneficiary elects not to use lifetime reserve days.

2. Nonpayment Code R

The intermediary uses code R in the following instances:

- The intermediary denies all SNF inpatient services for other than medical necessity or custodial care;
- Time limitation for filing expired before billing, and provider is at fault; or
- Patient refused to request benefits.

In these cases, there is technical liability but utilization is charged. Regional home health intermediaries (RHHIs) also use code R in the cases listed above, if applicable. Although there is no payment on the claim, some or all charges are submitted to CWF as covered, so that utilization is updated accurately.

3. Use of Nonpayment Code N in Cases Where Provider is Liable.

The intermediary uses code N in the following instances:

- Services or items were furnished by a provider who knew, or should have known, that Medicare would not pay for the Part A or Part B service or item,
- Services were found to be not reasonable and necessary or custodial care, or
- Provider failed to submit the requested documentation.

In these cases all charges are shown as noncovered, utilization is not charged and cost report days are applied.

4. Use of Nonpayment Code N in Cases Where Provider Is Not Liable.

The intermediary uses code N in the following instances:

- Services not covered under Part A (e.g., dental care, cosmetic surgery), excludes services determined to be medically unnecessary or custodial;
- Time limitation for filing expired before billing, and provider is not at fault;
- Limitation of liability decision finds beneficiary at fault;
- Inpatient psychiatric reduction applies because of days used before admission (see Medicare Benefit Policy Manual, Chapter 4);
- All services were provided after active care ended in a psychiatric hospital;
- All services were provided after the date a covered level of care ended (general hospital or SNF); or
- MSP cost avoidance denials. (See Medicare Secondary Payer Manuals.)

In these cases all charges are shown as noncovered and neither utilization nor cost report days are reported.

5. No Payment Situations Not Requiring a Nonpayment Code

The intermediary does not enter a nonpayment code in the following instances:

- Payment cannot be made because deductible/coinsurance exceeds the payment amount;
- EGHP, LGHP, auto/medical or no-fault insurance, WC (including BL), NIH, PHS, VA, or other governmental entity or liability insurance paid for all covered services; or

Services were provided to an HMO enrollee for which the HMO has jurisdiction for payment.

70 - Time Limitations for Filing Provider Claims to Fiscal Intermediaries and Carriers

(Rev. 830, Issued: 02-02-06, Effective: 07-01-06, Implementation: 07-03-06)

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 §70.7 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.

70.1 - Determining Start Date of Timely Filing Period--Service Date

(Rev. 1, 10-01-03)

Medicare determines the date services were furnished from dates submitted by the provider on the claim. For certain claims for services that 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:	Jul	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 service month.

70.2 - Definition of Claim

(Rev. 1, 10-01-03)

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 define 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.

70.2.1 - Appropriate Medicare Contractor

(Rev. 1, 10-01-03)

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 FI.

70.2.2 - Form Prescribed by CMS

(Rev. 1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

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-04 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 HIPAA 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 I, 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.

70.2.3 - In Accordance with CMS Instructions

(Rev. 1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

The CMS instructions for submitting institutional claims to Medicare are contained in this manual. General instructions that reflect guidance on the use of the paper UB-04, as established by the National Uniform Billing Committee, are found in Chapter 25. These instructions apply to all institutional claim types. Additional chapters in this manual supplement these general

instructions. For example, see instructions for inpatient hospital billing in Chapter 3, or inpatient skilled nursing billing in Chapter 6. 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.

70.2.3.1 - Incomplete or Invalid Submissions
(Rev. 1, 10-01-03)

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 incomplete 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 records of claims that are RTP are held in a temporary storage location in the FI's claims processing system. The records are held in this location for a period of time that may vary among FIs, 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 FI. If the incomplete or invalid information is not corrected within the temporary storage period, the electronic record is purged by the FI. There is no subsequent audit trail or other record of the submission being

received by Medicare. These submissions are never reflected on a RA. No permanent record is kept of the submissions because they are not considered claims under Medicare regulation.

70.2.3.2 - Handling Incomplete or Invalid Submissions

(Rev. 1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

The following provides additional information detailing submissions that are considered incomplete or invalid.

The matrix in Chapter 25 specifies whether a data element is required, not required, or conditional. (See definitions in §70.2 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). FIs should not deny claims and afford appeal rights for incomplete or invalid information as specified in this instruction. (See §80.3.1 for Definitions.)

The FIs 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, 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, the FI includes what is available.

- If a submission is RTP for incomplete or invalid information, the FI shall not report the submission on the MSN to the beneficiary. The notice must only be given to the provider or supplier.

The matrix in Chapter 25 specifies data elements that are required, not required, and conditional. These standard data elements are minimal requirements. A crosswalk is provided to relate CMS-1450 (UB-04) form locators used on paper submissions with loops and data elements on the ANSI X12N 837 I 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 837I for these specifications. If a claim fails edits for any one of these content or size requirements, the FI will RTP the submission to the provider of service.

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

The FIs must provide a copy of the matrix listing the data element requirements, and attach a brief explanation to providers and suppliers. FIs 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 RAs. Denials are subject to appeal, since a denial is a payment determination. Rejections may be corrected and re-submitted.

70.3 - Determining End Date of Timely Filing Period—Receipt Date
(Rev. 1, 10-01-03)

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 §70.2 above and is accepted into Medicare adjudication processes. At this point, the submission receives a permanent receipt date that remains part of the claim record.

The receipt date has two functions. It is used for determining whether the claim was timely filed (see 70.4 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 §80 for details on determining claims processing timeliness.)

70.4 - Determination of Untimely Filing and Resulting Actions
(Rev. 830, Issued: 02-02-06, Effective: 07-01-06, Implementation: 07-03-06)

Medicare denies a claim that is not filed timely as specified in §70.1. Medicare determines whether a claim has been filed timely by comparing 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 received. If the span between these two dates exceeds the time limitation specified in §70.1, the claim is considered to have been not timely filed. When a claim is denied for having been filed after the timely filing period, such denial does not constitute an “initial determination”. As such, the determination that a claim was not filed timely is not subject to appeal.

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 principle 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, the contractor shall apply the timely filing period for the fourth quarter of the calendar year to the entire claim.

70.5 - Application to Special Claim Types

(Rev. 1588; Issued: 09-05-08; Effective/Implementation Date: 08-18-08)

- 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 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 Chapter 29 on Reopenings).

- 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 §70.1 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.

If a beneficiary submits an initial claim within the timely filing period for payment of services on the Form CMS-1490S and the claim is incomplete and/or does not include an itemized bill

containing the information required by the Form CMS-1490S instructions or contains invalid information and the claim is returned to the beneficiary for completion or correction, consider the original claim submission by the beneficiary to extend the timely period for submission of a complete claim. A completed Form CMS-1490S claim that meets the requirements for the claim must be submitted to the appropriate Medicare contractor within 6 months after the month in which the Medicare contractor notified (see §70.8.8.6 and §70.8.8.7 below) the party who submitted the claim that the claim was incomplete or a complete claim must be submitted by the end of the applicable timely filling period, whichever is later. Apply these same timely filing procedures to Form CMS-1500 claims submitted by beneficiaries. In these cases, a complete Form CMS-1490S and itemized bill must be submitted within the above timeframes.

70.6 - Filing Claim Where Usual Time Limit Has Expired
(Rev. 1, 10-01-03)

As a general rule, where the contractor receives a late filed claim submitted by a provider with no explanation attached as to the circumstances surrounding the late filing, the contractor should assume that the provider accepts responsibility for the late filing.

Where it comes to the attention of a provider that health services that are or may be covered were furnished to a beneficiary but that the usual time limit (defined in §70.1 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 Chapter 3 for no-payment bill processing instructions.) Where the provider believes the beneficiary is responsible for late filing, it should contact the FI 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/her) 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.

- Where the provider believes Medicare or its agents are responsible for the late filing, see §70.7 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 the determination that he/she is responsible 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 FI may, at the request of the provider, informally review its initial determination.

70.7 - Exceptions Allowing Extension of Time Limit
(Rev. 211, 06-18-04)

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. Effective May 24, 2004, Medicare will no longer accept SOIs to extend the timely filing limit.

70.7.1 - Administrative Error

(Rev. 1, 10-01-03)

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 §70.1 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 FIs or carriers or SSA. FIs will not submit for approval requests for extensions for such errors that 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 that prevents timely filing of the claim may affect the provider directly or indirectly, i.e., by preventing the beneficiary or his or her 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 HI or SMI was not established until long after the month for which it is effective (e.g., a beneficiary is awarded two years of retroactive coverage).
- The failure resulted from SSA's failure to notify the individual that his or her entitlement to HI or SMI had been approved, or in giving him/her (or his/her representative or the provider) cause to believe that he or she is not entitled to HI or SMI.
- The failure resulted from misinformation from Medicare or the FI 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 FI, 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 FI (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 FI with a recommendation, before payment, to the appropriate CMS 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/her representative or the provider, depending on whom the error directly affected, as to how he/she learned of the error, and when it was corrected, and one of the following:
    - A written report by the agency (Medicare, SSA, carrier, FI) 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/her representative, or the provider is not essential if the other evidence establishes that his/her failure to file within the usual time limit resulted from administrative error, and that he/she filed a claim within six months after the month in which he/she 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 FI'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 SSO or to the CMS RO, the SSO or RO will forward any necessary report, statement and/or other evidence to the FI and will obtain and forward a request by the beneficiary or his/her representative for Medicare payment if such request was not previously filed with the provider or FI. The FI 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 three to four year period described above.

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

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/her representative), corroboration of such responsibility should be obtained since otherwise the beneficiary could be forced to pay substantial charges for which he/she 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 FI 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/her representative or relative) of the late filing, or pertinent information in the SSO's files.

The FI has the responsibility for deciding, on the basis of all pertinent circumstances, whether a late claim may be honored. The FI may ordinarily accept a statement from some other component that shows whether there was an administrative error that could reasonably have prevented or deterred the claimant from filing within the usual time limit. Similarly, the FI will ordinarily accept a statement from the component that corrected the error as to whether and when this was done. However, where information submitted to the FI by another component involved

in HI or SMI administration is incomplete or questionable, the FI may request clarification. Providers whose requests for exceptions on the basis of administrative error are denied may first request review from the appropriate CMS RO and in exceptional circumstances may then a request a final review from CMS Central Office.

70.7.2 – Statement of Intent (SOI)

(Rev. 493, Issued: 03-04-05, Effective: 04-04-05, Implementation: 04-04-05)

Effective May 24, 2004, Medicare contractors and ROs will no longer accept SOIs to extend the timely filing limit. The regulations at 42 CFR 424.45 have been eliminated. The timely filing period that ended December 31, 2003, for dates of service October 1, 2001 through September 30, 2002, was the last claims filing period that SOIs could have been timely filed. SOIs will not be accepted for the claims filing period ending December 31, 2004, for dates of service October 1, 2002 through September 30, 2003, and thereafter.

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 contractor (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 six 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.

70.7.3 – Reopening of Determinations

(Rev. 1, 10-01-03)

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 chapter 29, for instructions regarding reopenings.

70.8 - Filing Request for Payment to Carriers—Medicare Part B

(Rev. 493, Issued: 03-04-05, Effective: 04-04-05, Implementation: 04-04-05)

Medicare regulations at 42 CFR 424.44 define the timely filing period for Medicare fee-for-service claims. In general, claims must be filed on, or before, December 31 of the calendar year following the year in which the services were furnished. 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).

70.8.1 – Splitting Claims for Processing

(Rev. 170, 05-07-04)

There are a number of prescribed situations where a claim is received for certain services that require the splitting of the single claim into one or more additional claims. The splitting of such a claim is necessary for various reasons such as proper recording of deductibles, separating

expenses payable on a cost basis from those paid on a charge basis, or for accounting and statistical purposes. Split a claim for processing in the following situations:

- Expenses incurred in different calendar years cannot be processed as a single claim. A separate claim is required for the expenses incurred in each calendar year;

EXCEPTION FOR DURABLE MEDICAL EQUIPMENT REGIONAL CARRIERS (DMERCs):

Expendable items (disposable items such as blood glucose test strips and PEN nutrients) that will be used in a time frame that spans two calendar years and are required to be billed with appropriately spanned "from" and "to" dates of service may be processed on a single claim line. For these types of items, DMERCs must base pricing and deductible calculations on the "from" date, since that is the date when the item was furnished.

- A claim other than a DMERC claim that spans two calendar years where the "from" date of service is untimely but the "to" date of service is timely should be split and processed as follows:

1. Where the number of services on the claim is evenly divisible by the number of days spanned, assume that the number of services for each day is equal. Determine the number of services per day by dividing the number of services by the number of days spanned. Then split the claim into a timely claim and an untimely claim. Deny the untimely claim and process the timely claim.

2. Where the number of services on the claim is not evenly divisible by the number of days spanned and it is not otherwise possible to determine from the claim the dates of services, suspend and develop the claim in order to determine the dates of services. After determining the dates of services, split the claim accordingly into a timely claim and an untimely claim. Deny the untimely claim and process the timely claim.

- A claim containing both assigned and unassigned charges. Split assigned and unassigned services from non-participating physicians/suppliers into separate assigned and unassigned claims for workload counts and processing;

- Assigned claims from different physicians/suppliers (excluding group practices and persons or organizations to whom benefits may be reassigned). Process a separate claim for the services from each physician/supplier. Where the assigned claim is from a person or organization to which the physicians performing the services have reassigned their benefits, process all of the services as a single claim;

- A claim where there is more than one beneficiary on a single claim. There can only be one beneficiary per claim; and

NOTE: Roster bills for covered immunization services furnished by mass immunizers may be submitted for multiple beneficiaries. You must create individual claims for each Medicare beneficiary based on the roster bill information.

- Outpatient physical therapy services furnished on a cost basis by a physician-directed clinic cannot be processed when combined on the same claim with other charge-related services by the clinic. Process the cost related services as a separate claim.
- If an unassigned claim includes services by an independent physical therapist together with other physician services, process the physical therapy services as a separate claim. Process an assigned claim from an independent physical therapist as a single claim.
- A claim that is a duplicate of a claim previously denied is treated as a new claim if there is no indication that the claim is a resubmittal of a previous claim with additional information, or there is no indication on the second claim that the beneficiary is protesting the previous determination.
- In a claim containing services from physicians/suppliers covering more than one carrier jurisdiction, the carrier receiving the claim must split off the services to be forwarded to another contractor and count the material within the local jurisdiction as a claim. The carrier receiving the transferred material must also count it as a separate claim.
- When services in a claim by the same physician/supplier can be identified as being both second/third opinion services and services not related to second/third opinion, the "opinion" services must be split off from the "non-opinion" services and counted as a separate claim. When one physician/supplier in an unassigned claim has provided the "opinion" service and another physician(s)/supplier(s) has provided the "non-opinion" services, the claim may not be split.
- Claims containing any combination of the following types of services must be split to process each type of service as a separate claim. These services are:

    -- Physical therapy by an independent practitioner,

    -- outpatient psychiatric, or

    -- any services paid at l00 percent of reasonable charges.

    (Any of these types of services may be combined on the same claim with any other type of service.)

Do not deviate from defining claims as described above. Split claims in accordance with the appropriate definition. Throughout the claims process count each of the separate claims, resulting from the split, as an individual claim.

70.8.2 - Replicating Claims for Processing

(Rev. 170, 05-07-04)

There are no prescribed reasons other than those aforementioned for splitting claims and for counting additional claims into your workload. However, claims are frequently split for other reasons that are dictated by the systems or the methods of processing them. Such additional claims are labeled "Replicate Claims." Tally and report all replicate claims (other than those aforementioned) separately. Identify replicate claims and report them in the appropriate categories for claims. Some examples of replicate claims are:

- Additional claims created because of a line item limitation (regardless of the methodology used for coding line items);
- Extra claims created in making partial payments;

- Claims created for carving out individual specialty types of services and
- Extra claims created to apply special payment reductions (e.g., Gramm-Rudmann-Hollings) efficiently for applicable dates of service.

NOTE: For budget requests and cost reports (CMS-l524, CMS-l528, CMS-l6l6, and CMS-2599), the workload must exclude the number of replicate claims produced.

70.8.3 - Methods of Claiming Benefits for Services by Physicians and Suppliers

(Rev. 170, 05-07-04)

The method of claiming Part B benefits depends upon whether the patient is claiming payment or is assigning benefit payments to his/her source of medical treatment or services.

As a rule, beneficiaries do not submit claims for reimbursement. However, if there is reason for a beneficiary to submit a claim for reimbursement, the beneficiary uses the CMS-1490S. For covered services furnished on or after September 1, 1990, physicians and suppliers must complete and submit in accordance with SSA §1848(g)(4)(A) all Part B claims whether assigned or unassigned for beneficiaries who desire Medicare benefit payment determinations.

The physician/supplier (or the facility or organization to which the physician may reassign benefits, claims the payment. The patient or his representative agrees to assign the benefits and the physician/supplier agreeing to the assignment accepts the Medicare reasonable charge determination as the full charge for the services. (See §§3045ff. about specific assignment procedures and the nature and effect of assignments.)

70.8.4 - Claims Forms

(Rev. 1144, Issued: 12-29-06, Effective: 04-02-07, Implementation: 04-02-07)

A number of prescribed claims forms have been developed for use when requesting payment for Part B Medicare services. Many are printed and distributed nationally free of cost through CMS's Printing and Publications Branch. (See NOTE below for exception.)

In order to maintain control over the content and format of the forms, private printing of a Government form is not routinely permitted. However, if you or another organization wishes to independently print a prescribed claims form, the reproduction of a claims form must be in accordance with §422.527 of Title 20, Chapter III, Part 422 of the Code of Federal Regulations. Obtain CMS approval for printing a prescribed form. Route the written request for approval through the RO. Include the following:

- The reason or need for such reproduction;
- The intended user of the form;
- The proposed modifications or format changes, with printing or other specifications (such as realignment of data or line designations);
- The type of automatic data processing machinery, if any, for which the form is designed; and

- Estimates of printing quantity, cost per thousand, and annual usage.

NOTE: This procedure does not apply to the Form CMS-1500, Health Insurance Claim Form. Carriers, physicians and suppliers are responsible for purchasing their own forms. This form can be bought in single, multipart snap-out sets or in continuous pin-feed format. Medicare accepts any version. Forms can be obtained from local printers or printed in-house as long as it follows the CMS approved specifications developed by the American Medical Association.

The Form CMS-l490 was formerly the basic Part B claims form. It was replaced by Form CMS-l500 for claims completed by physicians and suppliers (except ambulance suppliers), and Form CMS-l490S for claims from beneficiaries. You must, however, continue to accept and process claims received on Form CMS-1490 form after conversion to Forms CMS-l500 and CMS-l490S.

The Form CMS-1500 (Health Insurance Claim Form), sometimes referred to as the AMA form, is the prescribed form for claims prepared and submitted by physicians or suppliers (except for ambulance services), whether or not the claims are assigned. It can be purchased in any version required i.e., single sheet, snap-out, continuous, etc.

The forms described below are printed and distributed to contractors by CMS and are available in single sheets, multipart snap-out sets, or in pin-feed format.

The Form CMS-1490S (Patient's Request for Medicare Payment) form is used only by beneficiaries (or their representatives) who complete and file their own claims. It contains only the first six comparable items of data that are on the Form CMS-1500. When the Form CMS-1490S is used, an itemized bill must be submitted with the claim. Social Security Offices use the Form CMS-1490S when assisting beneficiaries in filing Part B Medicare claims. For Medicare covered services received on or after September 1, 1990, the Form CMS-1490S is used by beneficiaries to submit Part B claims only if the service provider refuses to do so. Inasmuch as the Form CMS-1490S has no provision for an ICD-9 code, the ICD-9 code is not required at the time of claim submission.

The Form CMS-1556 (Prepayment Plan for Group Practices Dealing Through A Carrier) is used by plans which, for Medicare purposes are, both Group Practice Prepayment Plans, and are paid on the basis of reasonable charges related to their costs for furnishing services to their subscribers.

70.8.5 – Photocopies

(Rev. 170, 05-07-04)

Some enrollees may want to keep the original itemized physician and supplier bills for income tax or complementary insurance purposes. Photocopies of itemized bills are acceptable for Medicare deductible and payment purposes if there is no evidence of alteration.

70.8.6 – Time Limitation for Filing Part B Reasonable Charge and Fee Schedule Claims

(Rev. 830, Issued: 02-02-06, Effective: 07-01-06, Implementation: 07-03-06)

Medicare law prescribes specific time limits within which claims for benefits may be submitted with respect to physician and other Part B services payable on a reasonable charge or fee schedule basis (including those services for which the charge is related to cost). For these services, the terms of the law require that the claim be filed no later than the end of the calendar year following the year in which the service was furnished, except as follows:

- The time limit on filing claims for service furnished in the last 3 months of a year is the same as if the services had been furnished in the subsequent year. Thus, the time limit on filing claims for services furnished in the last 3 months of the year is December 31 of the second year following the year in which the services were rendered.

(Whenever the last day for timely filing of a claim falls on a Saturday, Sunday, Federal non-workday or legal holiday, the claim will be considered filed timely if it is filed on the next workday. Also note that a claim received by the contractor more than one year after the service has been rendered is subject to a 10 percent reduction.) When a claim is denied for having been filed after the timely filing period, such denial does not constitute an "initial determination". As such, the determination that a claim was not filed timely is not subject to appeal.

EXAMPLE: An enrollee received surgery in August 2000. He must file a claim for payment for such services on or before December 31, 2001. Note also that a service provided in October 2000, must be filed on or before December 31, 2002.

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

* The number specified in “Months to file” represents the number of full months remaining after the month in which the service was rendered.

70.8.7 – Improper Billing for Professional Component

(Rev. 170, 05-07-04)

In some cases, a hospital or other provider may have incorrectly billed for a Part B professional component as a provider expense. For example, this might occur when physicians' services were erroneously considered entirely administrative in nature and the error might be discovered in connection with the final cost settlement. Where such billings have been filed with a Part A intermediary within the time limit, this establishes protective filing for a subsequent filing of a Part B claim.

Such claims will be considered filed timely as of the date the incorrect billing was submitted to the intermediary provided the usual claims information (e.g., the Form CMS-1490S and itemized bill) is submitted within 6 months after the month in which the claimant is advised to furnish it or within the usual time limit, whichever is later.

The perfected claim may be filed by the physician on the basis of an assignment, or by the hospital (where the hospital has a contractual arrangement to bill and receive payment for the physician's services) or by the patient on the basis of an itemized bill. You and the intermediary should make your own arrangements regarding exchange of information and submission of the delayed claims. When there is more than one claim, it is preferable that they be submitted as a group.

A provider claim filed within the Part B time limit will not establish a filing date for the related professional component where such component was recognized and included in the provider bill, e.g., no claim was filed for the professional component as a nonprovider expense because the physician and hospital could not agree on the exact amount of the component charge or who would bill for it.

70.8.8 – Penalty for Filing Claims after One Year

(Rev. 170, 05-07-04)

Section 1848(g)(4) of the Social Security Act requires that physicians and suppliers complete and submit Part B claims for medical services, equipment and supplies (furnished on or after September 1, 1990) within 12 months of the service date. Only assigned claims submitted more than 12 months after the service date will be subject to a 10 percent reduction of the amount that would otherwise have been paid. Payment on an assigned claim submitted by a physician or other supplier 12 months or longer after the service is furnished, shall be reduced by 10 percent from the amount that would have otherwise been paid.

70.8.8.1 – Extend Time for Good Cause

(Rev. 420, Issued: 12-30-04, Effective: 01/31/05, Implementation: 01/31/05)

Extend the 1 year limit under §1848(g)(4), of the Social Security Act, claim filing provision if "good cause" is shown. Resolve the finding of good cause using the guidelines in §70.8.8.2 below. If an assigned claim is filed more than one year after the date of service, but within the time limits specified in §70.8.6, Chapter 1, of this manual, and if you determine that good cause exists, treat it as a timely-filed claim for payment and compliance monitoring purposes and waive the 10 percent payment reduction for that service. The time limit for filing may not be extended beyond the time limits specified in §70.8.6, chapter 1, of this manual, unless administrative error is applicable. If an assigned service is filed after the time limits specified in §70.8.6, chapter 1, of this manual, waive the 10 percent payment reduction only for administrative error.

70.8.8.2 – Conditions Which Establish Good Cause

(Rev. 420, Issued: 12-30-04, Effective: Effective: 01/31/05, Implementation: 01/31/05)

Good cause may be found when a physician or supplier claim filing delay was due to:

- Administrative error – that is, incorrect or incomplete information was furnished by official Medicare sources (e.g., carrier, intermediary, CMS) to the physician or supplier;
- Unavoidable delay in securing required supporting claim documentation or evidence from one or more third parties despite reasonable efforts by the physician/supplier to secure such documentation or evidence;

- Unusual, unavoidable, or other circumstances beyond the service provider's control which demonstrate that the physician or supplier could not reasonably be expected to have been aware of the need to file timely; or

- Destruction or other damage of the physician's or supplier's records unless such destruction or other damage was caused by the physician's or supplier's willful act or negligence.

70.8.8.3 – Procedure to Establish Good Cause

(Rev. 420, Issued: 12-30-04, Effective: 01/31/05, Implementation: 01/31/05)

If a claim for a service is filed after the expiration of the 1 year time period (for services furnished on or after September 1, 1990), apply the following procedures:

- If the claim includes an explanation for the delay (or other evidence which establishes the reason), determine good cause based primarily on that statement or evidence. If there is no such statement or other evidence, apply the 10 percent payment reduction to applicable assigned services.

- If the physician or supplier's statement for delay is sufficiently clear and is not controverted by other evidence, accept it. If other evidence leads you to doubt the validity of the statement, contact the physician or supplier for clarification or additional information necessary to make a "good cause" determination.

- If you find good cause on an assigned claim, do not apply the 10 percent payment reduction provided for in §70.8.8, chapter 1, of this manual and do not develop a claim submission violation.

70.8.8.4 – Good Cause is Not Found

(Rev. 420, Issued: 12-30-04, Effective: 01/31/05, Implementation: 01/31/05)

Monitor claim submission violations in accordance with §70.8.8.6 if you do not find good cause for late filing. In addition, if the claim is assigned, apply the 10 percent payment reduction to services on the claim for a service that was furnished on or after September 1, 1990 but the claim was not filed within one year. Approved charges applied to a beneficiary's Part B deductible are not subject to the 10 percent reduction. Send appropriate message(s) with your remittance advice, such as claim adjustment reason code B4, "Late Filing Penalty". Include an appropriate MSN message such as, MSN message 16.11, to advise the beneficiary of the payment reduction for late filing and to inform him/her that he/she is not liable for the 10 percent reduction.

70.8.8.5 – Preparing Common Working File (CWF) Claim Records for Services Subject to 10 Percent Payment Reduction

(Rev. 420, Issued: 12-30-04, Effective: 01/31/05, Implementation: 01/31/05)

Use the following instructions to prepare CWF claim records involving services subject to a 10 percent payment reduction.

Apply a 10 percent payment reduction to services that meet all of the following conditions:

- The service expense date is on or after September 1, 1990;

- The service is approved;

o The service expense date is more than one year before the claim receipt date and good cause for late filing does not apply; and

o The payment amount for the service is at least 10 cents.

When all of these conditions are met, reduce payment to the physician or supplier for applicable assigned services by 10 percent. (If multiple services are billed on a line item, apply the 10 percent payment reduction only to assigned services within the line item that are on or after September 1, 1990, and are received more than one year after the service date. If necessary, split line items within a claim in order to correctly apply the 10 percent reduction.) Display the payment reduction on your CWF claim record in the following fields:

o Payment to Provider field --Enter the payment amount resulting after the 10 percent penalty and any other applicable payment calculations are performed. Round to the nearest penny;

NOTE: If multiple payment rules apply (e.g., 10 percent reduction, interest, and/or Gramm-Rudman-Hollings), calculate the payment amount based on the following formula. Payment amount (after deductible, coinsurance and MSP rules are applied) minus the 10 percent payment reduction (Indicator F) plus clean claim interest (Indicator B) minus Gramm-Rudman-Hollings reductions (Indicator A).

o Other Amounts Applied field -- Enter the 10 percent payment reduction amount; and

o Other Amount Indicators field -- Enter the letter "F" to identify a service whose payment amount in the Payment to Provider field is reduced due to application of the 10 percent payment reduction provision.

70.8.8.6 – Monitoring Claims Submission Violations

(Rev. 1588; Issued: 09-05-08; Effective/Implementation Date: 08-18-08)

A. General

Section 1848(g)(4) of the Social Security Act requires physicians and suppliers to submit claims to Medicare carriers for services furnished on or after September 1, 1990. It also prohibits physicians and suppliers from imposing a charge for completing and submitting a claim. Payment for assigned services not filed within 1 year (for services on or after 9/1/90) are reduced 10 percent. Physicians and suppliers who fail to submit a claim or who impose a charge for completing the claim are subject to sanctions. CMS is responsible for assessing sanctions and monetary penalties for noncompliance.

Physicians and suppliers are not required to take assignment of Medicare benefits unless they are enrolled in the Medicare Participating Physician and Supplier Program or, in the case of physician services, the Medicare beneficiary is also a recipient of State medical assistance (Medicaid) or the service is otherwise subject to mandatory assignment.

B. Compliance Monitoring

To ensure that providers and suppliers are enrolled in the Medicare program and submit claims in compliance with the mandatory claims submission requirements found in §1848(g)(4) of the Social Security Act, contractors shall:

1) Process beneficiary claims submitted to A/B MACs or carriers for services that are not covered by Medicare (e.g., for hearing aids, cosmetic surgery, personal comfort services, etc.; see 42 CFR 411.15 for details), in accordance with its normal processing procedures;

2) Process beneficiary claims submitted to A/B MACs or carriers for services that are covered by Medicare and the beneficiary has submitted a complete and valid claim (Form CMS-1490S) and all supporting documentation associated with the claim, including an itemized bill with the following information, date of service, place of service, charge for each service, the doctor's or supplier's name, address, and the provider or supplier's National Provider Identifier. If a beneficiary submits a claim on the Form CMS-1500, manually return the Form CMS-1500 claim to the beneficiary, and include a copy of the Form CMS-1490S, along with a letter instructing the beneficiary to complete and return the Form CMS-1490S for processing within the time period prescribed in §70.5, above. Include in the letter a description of missing, invalid or incomplete items required for the Form CMS-1490S that were not included with the submitted Form CMS-1500 or were invalid.

3) Return as incomplete to the beneficiary, a beneficiary submitted claim submitted to an A/B MAC or carrier (Form CMS-1490S) for a Medicare-covered service if the claim is not complete or does not include all required supporting documentation or contains invalid information. In addition, the contractor shall maintain a record of the beneficiary-submitted claim for purposes of the timely filing rules in the event that the beneficiary re-submits the claim (see below). If a beneficiary submits a claim on the Form CMS-1500, return the Form CMS-1500 claim to the beneficiary, and include a copy of the Form CMS-1490S, along with a letter instructing the beneficiary to complete and return the Form CMS-1490S for processing within the time period prescribed in §70.5 above. Include in the letter a description of missing, invalid or incomplete items required for the Form CMS-1490S that were not included with the submitted Form CMS-1500 or were invalid.

When returning a beneficiary submitted claim, the contractor shall inform the beneficiary that the provider or supplier is required by law to submit a claim on behalf of the beneficiary (for services that would otherwise be payable), and that in order to submit the claim, the provider must enroll in the Medicare program. In addition, contractors shall encourage beneficiaries to always seek non-emergency care from a provider or supplier that is enrolled in the Medicare program.

If a beneficiary receives services from a provider or supplier that refuses to submit a claim to the A/B MAC or carrier, on the beneficiary's behalf, (for services that would otherwise be payable by Medicare), the beneficiary should:

(1) Notify the contractor in writing that the provider or supplier refused to submit a claim to Medicare, and

(2) Submit a complete Form CMS-1490S with all supporting documentation.

Upon receipt of both the beneficiary's complaint that the provider/supplier refused to submit the claim, and the submission of Form CMS-1490S and all supporting documentation, the contractor shall process and pay the beneficiary's claim if it is for a service that would be payable by Medicare were it not for the provider's or supplier's refusal to submit the claim and/or enroll in Medicare. Contractors shall maintain documentation of beneficiary complaints involving violations of the mandatory claims submission policy and a list of the top 50 violators, by State, of the mandatory claim submission policy.

Contractors are encouraged to educate providers and suppliers that they must be enrolled in the Medicare program before they submit claims for services furnished or supplied to any Medicare beneficiary.

The above policy is not applicable for foreign beneficiary claims submitted for covered services. These claims should be processed using guidelines for foreign claims.
The above policy is not applicable to beneficiary claims submitted to DMEMACs for durable medical equipment, prosthetics, orthotics, and supplies. These claims should be processed by DMEMACs using current procedures.

C. Exception When Physician, Other Practitioner, or Supplier Is Excluded From Participating in Medicare Program

Section 1848(g)(4) of the Social Security Act requires physicians, other practitioners, or suppliers to submit claims to Medicare carriers for services furnished after September 1, 1990. This **does not** apply to physicians, other practitioners, or suppliers who have been excluded from participating in the Medicare program. Physicians, other practitioners, and suppliers who have been excluded from the Medicare program are prohibited from submitting claims or causing claims to be submitted. See the Medicare Program Integrity Manual for procedures concerning claims submitted by an excluded practitioner, his/her employer, or a beneficiary for services or items provided by an excluded physician, other practitioner, or supplier. Carriers must maintain the systems capability to identify claims submitted by excluded physicians, other practitioners, or suppliers as well as items or services provided, ordered, prescribed, or referred by an excluded party.

When an excluded physician, other practitioner, or supplier has not submitted a claim on behalf of the beneficiary and/or the beneficiary has submitted the claim themselves, do **not** send a notification letter to the physician, other practitioner, or supplier warning of civil monetary penalties due to noncompliance with §1848(g)(4)(A) of the Act. Instead, follow the instructions in the Program Integrity Manual.

70.8.8.7 – Notification Letters

(Rev. 1588; Issued: 09-05-08; Effective/Implementation Date: 08-18-08)

A. The letter sent to the beneficiary should explain why the claim is being returned including an explanation of the corrections needed in order to process the claim. Also, include an explanation of the statutory requirement that providers and suppliers must submit claims for all covered services provided to Medicare beneficiaries. The letter should also provide the beneficiary with instructions on what should be done if the provider or supplier refuses to enroll with Medicare and/or submit the claim.

B. A letter shall also be sent to the provider or supplier explaining the statutory requirement for submitting claims for all services rendered to Medicare beneficiaries. The letter should explain to the provider or supplier that they are required to enroll with the Medicare program before a claim can be submitted. Finally the letter should include language explaining the penalties for failure to comply with the mandatory claims submission requirements.

70.8.8.8 - Violations That Are Not Developed For Referral

(Rev. 420, Issued: 12-30-04, Effective: 01/31/05, Implementation: 01/31/05)

Claim submission violations need not be developed on beneficiary-submitted Form CMS-1490S claims that include approved charges for services performed on or after September 1, 1990 in the following situations:

- o Used DME purchases from private sources;
- o Cases in which a physician/supplier does not possess information essential for filing a MSP claim. Assume this is the case if the beneficiary files a MSP claim and encloses the primary insurer's payment determination notice and there is no indication that the service provider was asked to file but refused to do so;
- o Services paid under the indirect payment procedure;
- o Foreign claims; and
- o Other unusual or unique situations that you evaluate on a case-by-case basis.

NOTE: It is unlikely that knowing, willful, and repeated noncompliance will apply in the above situations.

70.8.9 – Extension of Time Limitation for Filing Part B Claims on Charge Basis Because of Administrative Error

(Rev. 170, 05-07-04)

Medicare law extends the time limitation for filing claims payable on a reasonable charge basis, if:

- The failure to submit the claim within the timeframes specified in §3004.A. was due to "administrative error" (i.e., misrepresentation, delay, mistake or other action) of an officer, employee, FI, carrier, or agent of the DHHS performing functions under the Medicare program, and acting within the scope of his/her authority; and
- The claim is filed promptly (see subsection B for definition) after the "error" is corrected.

The time limit provided by the law has been adequate for the great majority of claims. However, potential claimants (enrollees, their representatives or assignees) have failed to file timely claims due to an administrative error. For example, in some unusual cases the failure was caused by misinformation from an official source, a delay in establishing SMI entitlement, or some administrative action which appeared to be correct on the basis of information available at the time, but resulted in delaying the filing of a claim.

An extension of the time limits applies only if the delay resulted primarily from some administrative error. The fact that the enrollee was "without fault" or otherwise showed "good cause" for his failure to submit a claim timely is not a basis for extending the time limits, in the absence of administrative error.

Relief may be given in any case which comes to light in the normal routine of work provided it meets the criteria outlined in subsection A. Neither you nor SSA will conduct a search for such claims.

70.8.10 – Delays Considered to be the Result of Administrative Error

(Rev. 170, 05-07-04)

Situations in which failure to file within the normal time limit will be considered to have been caused by administrative error include, but are not limited to, the following:

- The failure resulted from SSA's delay in establishing the individual's entitlement to SMI until many months after SMI coverage was effective. Until the enrollee's name is entered on the SMI rolls, he has no basis for claiming SMI benefits, since any SMI benefit claims made would have been disallowed;
- The failure to file resulted from SSA's failure to notify the individual that his enrollment application had been approved, or in giving him (or his representative or assignee) cause to believe that he was not entitled to SMI;
- The failure resulted from misinformation from you or SSA, e.g., that certain services were not covered under SMI although in fact, they were covered; or
- Because of a policy or other issue, you advise the physician or supplier to hold his claims until further notice and do not advise him timely to resume submitting them.

Submit any claim with a recommendation before payment involving situations other than those listed above in which it appears that an extension of the time limit might be justified on the basis of administrative error to your Regional Office for a particular situation. If the issue has a national implication the Regional Office will refer the matter to the Central Office.

70.8.11 – Extension of Time Limit in Reference to Definition of "Filed Promptly"

(Rev. 170, 05-07-04)

Where failure to file a claim within the usual time limit results from an administrative error, the claim will be deemed filed promptly and timely if it is filed within 6 calendar months following the month in which the error is corrected. A claimant always has at least 6 calendar months after the month of correction in which to file. Correction of the error less than 6 full calendar months before expiration of the usual time limit will warrant an extension of time for the remainder of the 6 months.

EXAMPLE 1: Information submitted in connection with a claim for services during the period May 1989-September 1989, filed in March 1991, shows that the enrollee's request for enrollment in SMI was initially denied. He/she was first notified on January 15, 1991, that he/she had SMI effective May 1989. Under these circumstances, pay appropriate SMI benefits for the services. Although the usual

time limit expired December 31, 1990, the error in this case - delay in establishing SMI entitlement - was not corrected until January 15, 1991, thus extending the time limit to July 31, 1991.

EXAMPLE 2: An individual requested enrollment in SMI in March 1989, the month before he attained age 65. He/she received covered services in July 1989, but filed no claim because he/she had received no notice of his/her SMI entitlement. Such notice was mailed to him/her on October 3, 1990. Although the regular time limit for the services in July 1989, expired on December 31, 1990, the claim will be considered promptly and timely filed if it is filed on or before April 30, 1991 (within the 6-month period following the month in which the notice was sent).

70.8.12 – Initiating Development of Administrative Error

(Rev. 170, 05-07-04)

Consider extending the time limit only if there is some reasonable basis for concluding that the claimant (the enrollee or his/her representative or assignee) was prevented from timely filing by administrative error, e.g., he/she states that official misinformation has caused late filing, or the Social Security office calls to your attention a situation in which such an error has caused late filing. Do not routinely initiate development for such a possibility. Make no search for possible administrative cause for delay in filing among cases previously denied because of the time limit. If a previously denied claim containing such an allegation or other basis for inferring such error comes to your attention, reexamine the case.

70.8.13 – Evidence Necessary to Honor Late Claims

(Rev. 170, 05-07-04)

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

- A statement from the claimant, his/her representative, or assignee regarding the nature and affect of the error, how he/she learned of the error, when it was corrected, and if the claim was filed previously, when it was filed; and
- One of the following:
  - A written report by the agency or other responsible party (SSA, CMS), based on its own records, describing how its error caused failure to file within the usual time limit;
  - Copies of an official 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 claimant 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 fault 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 carrier's own records, it should annotate the claims file to this effect.

70.8.14 – Responsibility for Decision on Extension of Time Limit

(Rev. 170, 05-07-04)

The carrier has the responsibility for deciding, on the basis of all pertinent circumstances, whether a late claim may be honored. The carrier will ordinarily accept a statement from some other component which shows that there was (not) error, as a result of which the claimant could reasonably have been prevented or deterred from filing his claim within the usual time limit. Similarly, the carrier 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 carrier by another component involved in SMI administration is incomplete or questionable, the carrier may request clarification. (See 70.8.15)

70.8.15 – Coordination of Development with Social Security Administration, Carriers, and Intermediaries

(Rev. 170, 05-07-04)

Where the initial allegation of administrative error on the part of the Government is made to SSA, the servicing SSO will forward any necessary report, statement, and/or other evidence to the carrier.

There may be situations in which the enrollee still owes for services during a period for which the time limit has expired and it is clear that an extension of the time limit will apply on the basis of administrative error if a claim is now filed promptly. If the enrollee wishes to assign the claim and the enrollee or the SSO believes that the physician (or supplier) may be willing to accept assignment, the SSO will give the enrollee a report of the kind described above for the physician to attach to the assigned claim, and (when necessary) call the physician's office to explain both the time limit and the need for prompt filing of the claim.

If an allegation of administrative error by the SSA is made to the carrier or if the information furnished by the SSO is incomplete, the carrier will request the necessary evidence (see D above), from the SSO servicing the enrollee. Such request may be made on Form SSA-l980-Carrier or Intermediary Request for SSA Assistance and, unless RO instructions provide otherwise, will be made through the parallel SSO. Where allegedly another carrier or intermediary is involved in the delay, the request for and the furnishing of necessary information and evidence may be made by letter.

70.8.16 – Statement of Intent (SOI)

(Rev. 493, Issued: 03-04-05, Effective: 04-04-05, Implementation: 04-04-05)

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 §70.8.6 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 must be submitted to the appropriate Medicare contractor within six 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.

Effective May 24, 2004, Medicare carriers and ROs will no longer accept SOIs to extend the timely filing limit. The regulations at 42 CFR 424.45 have been eliminated. The timely filing period that ended December 31, 2003, for dates of service October 1, 2001 through September 30, 2002, was the last claims filing period that SOIs could have been timely filed. SOIs will not be accepted for the claims filing period ending December 31, 2004, for dates of service October 1, 2002 through September 20, 2003, and thereafter.

70.8.17 – Time Limitation of Claims for Outpatient Physical Therapy or Speech Language Pathology Services Furnished by Clinic Providers

(Rev. 980, Issued: 06-14-06, Effective: 10-01-06, Implementation: 10-02-06)

Effective with respect to claims filed after December 3l, l974, claims for payment for services reimbursable on a reasonable cost basis are subject to the same limitation as claims for payments for services reimbursable on a reasonable charge basis (including a charge-related-to-cost basis). (The only Medicare claims for payments reimbursable strictly on a reasonable cost basis under the carriers' jurisdiction are those relating to outpatient physical therapy or speech-language pathology services furnished by clinic providers. There was no time limit on filing for such services for claims submitted before January l, l975.) In the case of services reimbursable on a reasonable cost basis, administrative error of SSA or its agents will not ordinarily extend the time limit beyond the close of the third year following year in which the services were furnished (deeming services furnished in the last quarter of the year to have been furnished in the following year).

EXAMPLE: Mr. G. receives outpatient physical therapy services on January 05, 1995 at Clinic X, a participating provider. For reimbursement for these services, the claim must be submitted to the carrier no later than December 31, 1996. If the services were furnished on October 15, 1995, the services would be deemed to be furnished in l996, and the claim would have to be submitted by December 31, 1997. If the services were furnished on October 15, 1992, the claim must have been submitted by l2/3l/94, the effective date of the time limit. If administrative error prevents the claim for services furnished on October 15, 1992 from being filed until after l996, the fourth year after the fourth quarter of l992, the case should be submitted to BHI for advice.

If an enrollee request for payment is filed with the provider timely (or would have been filed timely had the provider taken action to obtain a request from a patient whom the provider knew or had good reason to believe was an enrollee) but the provider does not file a timely claim, the provider may not charge him for the services except for such deductible and/or coinsurance amounts and noncovered services as would be appropriate if Medicare payment were made.

80 - Carrier and FI Claims Processing Timeliness

(Rev. 1, 10-01-03)

A3-3600, A3-3600.1, B3-13306, HO-401, HO-401A, HH-462, B2-5240.11

Carriers and FIs must establish control records for timely claims processing as described below.

80.1 - Control and Counting Claims

(Rev. 1, 10-01-03)

The carrier or FI will consider claims as received for timely processing purposes from the date of their receipt. Improperly completed claims that it returns are considered received for timely processing purposes when received again, properly completed.

A. Provider Billing Via Terminal or Equivalent

If the provider bills via remote terminal with on-site (in the provider) editing or if the carrier or FI otherwise can communicate edit results to it electronically, the carrier or FI establishes a control record when the bill passes its consistency edits.

B. Manual Hardcopy Claim/Bills and Electronic Claim/Bills

The carrier or FI establishes a control record when it enters the initial claim into its system. The claim is counted for administering timely billing and payment only if it passes carrier or FI edits to the extent a pending record can be established. The date received is the date the carrier or FI received the claim properly completed, passing all carrier or FI edits, even if entered into its system on a later date.

C. Bills Returned to Provider

If the carrier or FI returns the bill and retains a claim record to minimize data entry cost when returned, the receipt date is corrected when the bill is properly completed and passes carrier or FI edits.

D. Bills Requiring Medical Information

When a carrier or FI requests medical documentation, it retains the bill as a pending record until it either pays, denies, or rejects (in the case of FIs) it. Returning cases for review by the PRO is not a request for medical documentation. Claims that fail initial carrier or FI edits because required medical reports or other required attachments are not included are also not requests for medical documentation.

E. Adjustment and Cancel Bills

An adjustment request bill is a correction to a claim previously processed. The carrier or FI establishes a control record for it.

The carrier or FI counts adjustments as received and pending only when they pass carrier or FI edits. The carrier or FI assigns the date received in its mailroom as the receipt date for hospital and MSP adjustment requests.

The carrier or FI counts adjustment bills as processed when no further action by it is required. The final action taken on the adjustment request bill depends upon the situation.

80.2 - Definition of Clean Claim

(Rev. 1, 10-01-03)

HO-401.D, A3-3600.1, B2-5240.11.A

A “clean” claim is one that does not require the carrier or FI to investigate or develop external to their Medicare operation on a prepayment basis. Clean claims must be filed in the timely filing period.

The following bullets are some examples of what are considered clean claims:

- Pass all edits (contractor and Common Working File (CWF)) and are processed electronically);

- Not require external development (i.e., are investigated within the claims, medical review, or payment office without the need to contact the provider, the beneficiary, or other outside source) (Note: these claims are not included in CPE scoring).
- Claims not approved for payment by CWF within 7 days of the FI's original claim submittal for reasons beyond the carrier's, FI's or provider's control (e.g., CWF system/communication difficulties);
- CWF out-of-service area (OSA) claims. These are claims where the beneficiary is not on the CWF host and CWF has to locate and identify where the beneficiary record resides;
- Claims subject to medical review but complete medical evidence is attached by the provider or forwarded simultaneously with EMC records in accordance with the carrier's or FI's instructions;
- Are developed on a postpayment basis; and,
- Have all basic information necessary to adjudicate the claim, and all required supporting documentation

80.2.1 - Receipt Date

(Rev. 273, Issued 08-13-04, Effective: 07-01-04, Implementation: 07-06-04)

A3-3600.1-Item 7

The receipt date of a claim is the date the contractor receives the claim (provided the filing is in a format and contains data sufficiently complete so that the filing qualifies as a claim). The receipt date is used to: determine if the claim was timely filed (see §70.3), determine the "payment floor" for the claim (see §80.2.1.2), determine the "payment ceiling" on the claim (see §80.2.1.1) and, when applicable, to calculate interest payment due for a clean claim that is not timely processed, and to report to CMS statistical data on claims, such as in workload reports.

A paper claim that is received by 5:00 p.m. on a business day, or by closing time if the contractor routinely ends its public business day between 4:00 p.m. and 5:00 p.m., must be considered as received on that date, even if the contractor does not open the envelope which contains the claim or does not enter the claims data into the claims processing system until a later date. A paper claim that is received after 5:00 p.m., or after the contractor's routine close of business between 4:00 p.m. and 5:00 p.m., is considered as received on the next business day.

A paper claim is considered as received if it is delivered to the contractor's place of business by the U.S. Postal Service, picked up from a P.O. box, or is otherwise delivered to the contractor's place of business by its routine close of business time. If the contractor uses a P.O. box for receipt of mailed claims, it must have its mail picked up from its box at least once per business day unless precluded on a particular day by the emergency closing of its place of business or that of its postal box site.

As electronic claim tapes and diskettes that may be submitted by providers or their agents to an FI are also subject to manual delivery, rather than direct electronic transmission, the paper claim receipt rule also applies to establish the date of receipt of claims submitted on such manually delivered tapes and diskettes.

Electronic claims transmitted directly to a contractor, or to a clearinghouse with which the contractor contracts as its representative for the receipt of its claims, by 5:00 p.m. in the contractor's time zone, or by its closing time if it routinely closes between 4:00 p.m. and 5:00

p.m., must likewise be considered as received on that day even if the contractor does not upload or process the data until a later date. **NOTE:** The differentiation between HIPAA-compliant and HIPAA-non-compliant electronic claims that is specified in §80.2.1.2 with respect to applying the payment floor, does not apply to establishing date of receipt. Use the methodology described above to establish the date of receipt for all electronic claims.

Paper and electronic claims that do not meet the basic legibility, format, or completion requirements are not considered as received for claims processing and may be rejected from the claims processing system. Rejected claims are not considered as received until resubmitted as corrected, complete claims. The contractor may not use the data entry date, the date of passage of front-end edits, the date the document control number is assigned, or any date other than the actual calendar date of receipt as described above to establish the official receipt date of a claim.

The following permissive exception applies to establishment of receipt date: Where its system or hours of operation permit, a contractor may, at its option, classify a paper or electronic claim received between its closing time and midnight, or on a Saturday, Sunday, holiday, or during an emergency closing period as received on the actual calendar date of delivery or receipt. Unless a contractor closes its place of business early in an isolated situation due to an emergency, the contractor's cutoff time for establishing the receipt date may never be earlier than 4:00 p.m.

A contractor may not make system changes, extend its hours of operation, or incur significant additional costs solely to begin to accommodate late receipt of claims if not already equipped to do so.

The cutoff time for paper claims may not exceed the cutoff time for electronic claims. However, the cutoff time for electronic claims may exceed the cutoff time for paper claims and, indeed, carriers and FIs are encouraged to use this tool where their system and overnight batch run schedules permit. Likewise, at a carrier or FI's option, it may consider electronic claims received on a weekend or holiday as received on the actual calendar date of receipt, even though paper claims received in a P.O. box on a weekend or holiday would not be considered received until the next business day.

Where a carrier or FI prepares bills for payment for purchased DME because the $50 tolerance is exceeded (see §40.4.1) it establishes any date consistent with its system processing requirements as the receipt date for the second and succeeding bills. It uses the date as close to its payment as possible.

80.2.1.1 - Payment Ceiling Standards

(Rev. 454, Issued: 01-28-05, Effective: 04-01-05, Implementation: 04-04-05)

Payment ceilings were implemented for clean claims received by the carrier or FI on or after April 1, 1987. "Clean" claims must be paid or denied within the applicable number of days from their receipt date as follows:

Time Period for Claims Received	Applicable Number of Calendar Days
01-01-93 through 09-30-93	24 for EMC and 27 for paper claims
10-01-93 and later	30

All claims (i.e., paid claims, partial and complete denials, no payment bills) including PIP and EMC claims are subject to the above requirements.

Interest must be paid on claims that are not paid within the ceiling period.

The count starts on the day after the receipt date and it ends on the date payment is made. For example, for clean claims received October 1, 1993, and later, if this span is 30 days or less, the requirement is met.

The RAPs submitted by home health agencies under the HH PPS (records with type of bill 322 or 332 and dates of service on or after October 1, 2000) are not Medicare claims as defined under the Social Security Act. Since they are not considered claims, they (records with type of bill 322 or 332 and dates of service on or after October 1, 2000) are not subjected to payment ceiling standards and interest payment.

See Chapter 24, § 30.2 for definitions of electronic and paper claims for use in application of the Medicare payment floor. See Chapter 1, § 80.2.1.2 for differentiation between electronic claims that comply with the requirements of the standard implementation guides adopted for national use under HIPAA and those submitted electronically using pre-HIPAA formats supported by Medicare. This HIPAA format differentiation applies to the payment floor, but not to the ceiling.

80.2.1.2 - Payment Floor Standards

(Rev. 1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

The “payment floor” establishes a waiting period during which time the contractor may not pay, issue, mail, or otherwise finalize the initial determination on a clean claim. The “payment floor date” is the earliest day after receipt of the clean claim that payment may be made.

The payment floor date is determined by counting the number of days since the day the claim was received, i.e., the count begins the day after the day of receipt.

There are different waiting periods, and thus different payment floor dates, for electronic claims and paper claims. The waiting periods are 13 days for electronic claims and 26 days for paper claims. For the purpose of implementing the payment floor, the following definitions apply:

An “electronic claim” is a claim submitted via central processing unit (CPU) to CPU transmission, tape, direct data entry, direct wire, or personal computer upload or download. A claim that is submitted via digital FAX/OCR, diskette, or touch-tone telephone is not considered as an electronic claim.

A “paper claim” is submitted and received on paper, including fax print-outs. This also includes a claim that the contractor receives on paper and then reads electronically with OCR technology.

Also, for the purpose of implementing the payment floor, effective 7/1/04 and for the duration of the HIPAA contingency plan implementation, an electronic claim that does not conform to the requirements of the standard implementation guides adopted for national use under HIPAA, including electronic claims submitted electronically using pre-HIPAA formats supported by Medicare, is considered to be a paper claim.

Based on the waiting periods, the payment floor dates are as follows:

Claim Receipt Date	Payment Floor Date
10-01-93 through 6/30/04	14th day for EMC 27th day for paper claims
07-01-04 and later	14th day for HIPAA-compliant EMC 27th day for paper and non-HIPAA EMC
01/01/2006 and later	29th day for paper

Except as noted below, the payment floor applies to all claims. The payment floor does not apply to: "no-payment claims, RAPs submitted by Home Health Agencies, and claims for PIP payments.

NOTE: The basis for treating a non-HIPAA-compliant electronic claim as a paper claim for the purpose of determining the applicable payment floor is as follows: Effective October 16, 2003, HIPAA requires that claims submitted to Medicare electronically comply with standard claim implementation guides adopted for national use under HIPAA. A claim submitted via direct data entry (DDE), if DDE is supported by the contractor is considered to be a HIPAA-compliant electronic claim. A contingency plan has been approved to enable claims to continue to be submitted temporarily after October 15, 2003 in a pre-HIPAA electronic format supported by Medicare. Effective July 1, 2004, the Medicare contingency plan is being modified to encourage migration to HIPAA formats. Effective July 1, 2004, for purposes of the payment floor, only those claims submitted in a HIPAA-compliant format will be paid as early as the 14th day after the date of receipt. Claims submitted on paper after July 1, 2004 will not be eligible for payment earlier than the 27th day after the date of receipt. All claims subject to the 27-day payment floor, including non-HIPAA electronically submitted claims, are to be reported in the paper claims category for workload reporting purposes. Effective January 1, 2006, paper claims will not be eligible for payment earlier than the 29th day after the date of receipt.

This differentiation in treatment of HIPAA-compliant and non-HIPAA-compliant electronic claims does not apply to Contractor Performance Evaluation (CPE) reviews of carriers and FIs conducted by CMS. For CPE purposes, carriers and FIs must continue to process the CPE specified percentage of clean paper and clean electronic (HIPAA or non-HIPAA) claims within the statutorily specified timeframes. Effective for claims received January 1, 2006 and later, clean paper claims will no longer be included in CPE scoring for claims processing timeliness.

80.2.2 - Interest Payment on Clean Non-PIP Claims Not Paid Timely

(Rev. 416, Issued: 12-23-04, Effective: 01-25-05, Implementation: 01-25-05)

Interest must be paid on clean claims if payment is not made within the applicable number of calendar days (i.e., 30 days) after the date of receipt as described above. The applicable number of days is also known as the payment ceiling. For example, a clean claim received on October 1, 1993, must have been paid before the end of business on October 31, 1993. Interest is not paid on:

- Claims requiring external investigation or development by the provider's FI or carrier;
- Claims on which no payment is due;
- Full denials;
- Claims for which the provider is receiving PIP; or
- HH PPS RAPs

Interest is paid at the rate used for §3902(a) of title 3l, U.S. Code (relating to interest penalties for failure to make prompt payments). The interest rate is determined by the applicable rate on the day of payment.

This rate is determined by the Treasury Department on a 6-month basis, effective every January and July 1. Providers may access the Treasury Department Web page, http://www.publicdebt.treas.gov/opd/opdprmt2.htm, for the correct rate. Also, the carrier or FI notifies the provider of any changes to this rate.

Interest is calculated using the following formula:

Payment amount x rate x days divided by 365 (366 in a leap year) = interest payment

The interest period begins on the day after payment is due and ends on the day of payment.

NOTE: The example below is for one 6-month period in which the interest rate was 5.625 percent.

Milestones	**Clean Paper Claim (in calendar days)**	**Clean Electronic Claim (in calendar days)**
Date Received	November 1, 2001	November 1, 2001
Payment Due	December 1, 2001	December 1, 2001
Payment Made	December 4, 2001	December 4, 2001
Interest Begins	December 2, 2001	December 2, 2001
Days for Which Interest is Due	3	3
Amount of Payment	$100	$100
Interest Rate	5.625%	5.625%

See section 80.2.1.1 for the definition of EMC and paper claims.

The following formula is used:

For the clean paper claim - $100 X .05625 X 3 divided by 365 = $.0462 or $.05 when rounded to the nearest penny.

For the clean electronic claim - $100 X .05625 X 3 divided by 365 = $.0462 or $.05 when rounded to the nearest penny.

When interest payments are applicable, the FI or carrier reports the amount of interest on each claim on the remittance record to the provider.

PIP/Non-PIP:

Under the periodic interim payment ("PIP") mechanism, a provider receives flat biweekly payments to approximate the average costs of covered inpatient services during a 2-week period. Non-PIP claims are claims made by a provider not under the periodic interim payment mechanism. PIP on inpatient bills does not preclude interest payments on outpatient bills. Interest is paid on a per bill basis at the time of payment.

80.2.2.1 - Determining and Paying Interest

(Rev. 273, Issued 08-13-04, Effective: 07-01-04, Implementation: 07-06-04)

The contractor must pay interest on clean, non-PIP (FIs) claims for which it does not make payment within the payment ceiling specified in § 80.2.1.1, provided payment is due on such claim. The interest rate and formula for calculation are shown above. The interest rate is determined by the rate applicable on the carrier or FI's payment date.

The contractor applies interest to the net payment amount after all applicable deductions are determined (e.g., deductible, copayment, and/or MSP). Interest is rounded to the nearest penny.

A. Reporting Interest Payment on Remittance Record

See 100-22 for remittance advice completion instructions.

B. Payment Made to Beneficiary

If interest is paid on a claim for which payment is made directly to the beneficiary, the contractor adds the following messages on the beneficiary notice:

"Your payment includes interest since we were unable to process your claim timely."

C. Claims Paid Upon Appeal

Interest payments are not payable on clean claims initially processed to denial and on which payment is made subsequent to the initial decision as a result of an appeal request. This applies to appeals where more than the applicable number of days elapsed before an initial denial, but the claim was later paid upon appeal. Where an appeal of a previously paid claim results in increased payment FIs follow the following section.

D. Interest on Postpayment Denials and Other Adjustments

If a paid claim is later denied in full, the carrier or FI recovers any interest paid as well as the incorrect payment. It does not pay interest on the related no payment bill. If the claim is partially denied, interest is payable on the reduced amount. The FI recalculates the interest due based upon the new reimbursement amount. It uses the rate of interest and elapsed days applicable to the original claim. This can be accomplished by applying a ratio of the new reimbursement amount (from its debit action) to the reimbursement amount on the initial claim (from its credit action). It multiplies the result by the interest amount paid on the initial claim. The result is the interest amount payable on its debit action. The following formula is used to calculate interest:

$$\text{Interest} = \frac{\text{Debit action reimbursement amount}}{\text{Credit action reimbursement amount}} \times \text{original interest paid}$$

Use of the formula is preferable to expanding an FI system to handle multiple scheduled payment dates and calculation procedures.

80.2.2.2 - Preparation of IRS Form 1099-INT

(Rev. 1, 10-01-03)

The IRS requires that interest paid in the course of a "trade or business" be reported if it totals at least $600 for any person. Interest payments a carrier or FI makes fall within the "trade or business" definition. Therefore, FIs and carriers must prepare and file with the IRS, Form 1099-INT when interest payments for a calendar year to a beneficiary or provider total at least $600. The carrier or FI uses the beneficiary's individual Social Security Number (SSN) to report interest paid to the beneficiary. Individual SSNs are identified by the suffix A or M, J, T, or TA. Other suffixes mean benefits are based upon a spouse's, parent's or child's (F1 thru 8) SSN. If the spouse's, parent's or child's SSN is involved, the FI determines the individual's SSN to report interest. If the individual's SSN is not present, the carrier or FI calls its Social Security Office contact for the information.

80.3 - Other Claims (other than clean)

(Rev. 1, 10-01-03)

A3-3600.1 Item 4, HO-401.E, B2-5240.11.B

Claims that do not meet the definition of "clean" claims are "other" claims. "Other" claims require investigation or development external to the carrier or FI's Medicare operation on a prepayment basis. "Other" claims are those that are not approved by CWF for payment that the FI identifies as requiring outside development. Examples are claims on which the provider's FI/carrier:

- Requests additional information from the provider or another external source. This includes routine data omitted from the bill, medical information, or information to resolve discrepancies;

- Requests information or assistance from another contractor. This includes requests for charge data from the carrier, or any other request for information from the carrier;

- Develops Medicare Secondary Payer (MSP) information;

- Requests information necessary for a coverage determination;

- Performs sequential processing when an earlier claim is in development; and

- Performs outside development as a result of a CWF edit.

80.3.1 - Incomplete or Invalid Claims Processing Terminology

(Rev. 1588; Issued: 09-05-08; Effective/Implementation Date: 08-18-08)

The following definitions apply to §80.3.2. For carriers the requirements apply to Part B assigned and unassigned claims (Form CMS-1500) or electronic data interchange equivalent.

Unprocessable Claim - Any claim with incomplete or missing, required information, or any claim that contains complete and necessary information; however, the information provided is invalid. Such information may either be required for all claims or required conditionally.

Incomplete Information - Missing, required or conditional information on a claim (e.g., no Unique Physician Identification Number (UPIN) / Provider Identification Number (PIN) or National Provider Identifier (NPI) when effective).

Invalid Information - Complete required or conditional information on a claim that is illogical, or incorrect (e.g., incorrect UPIN/PIN or NPI when effective), or no longer in effect (e.g., an expired number).

Required - Any data element that is needed in order to process a claim (e.g., Provider Name, Date of Service).

Not Required - Any data element that is optional or is not needed by Medicare in order to process a claim (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 or if the insured is different from the patient, then the insured's name must be entered on a claim).

Return as Unprocessable or Return to Provider (RTP)- Returning a claim as unprocessable to the provider (RTP) does not mean that the carrier or FI should physically return every claim it received with incomplete or invalid information. The term "return to provider" is used to refer to the many processes utilized today for notifying the provider or supplier of service that their claim cannot be processed, and that it must be corrected or resubmitted. Some (not all) of the various techniques for returning claims as unprocessable include:

- Incomplete or invalid information is detected at the front-end of the carrier or FI claims processing system. The claim is returned to the provider (RTP'd) either electronically or in a hardcopy/checklist type form explaining the error(s) and how to correct the errors prior to resubmission. Claim data are not retained in the system for these RTP'd claims. No RA is issued.

- Incomplete or invalid information is detected at the front-end of the claims processing system and is suspended and developed. If requested corrections and/or medical documentation are submitted within a 45-day period, the claim is processed. Otherwise, the suspended portion is returned and the supplier or provider of service is notified by means of the RA.

- Incomplete or invalid information is detected within the claims processing system and is rejected through the remittance process. Suppliers or providers of service are notified of any error(s) through the remittance notice and how to correct prior to resubmission. A record of the claim is retained in the system (**NOTE:** This applies to carriers only. FIs do not use the remittance advice process for return to provider (RTP)).

A claim returned as unprocessable for incomplete or invalid information does not meet the criteria to be considered as a claim, is not denied, and, as such, is not afforded appeal rights.

80.3.2 - Handling Incomplete or Invalid Claims

(Rev. 1588; Issued: 09-05-08; Effective/Implementation Date: 08-18-08)

Claims processing specifications describe whether a data element is required, not required, or conditional (a data element which is required when certain conditions exist). The status of these data elements will affect whether or not an incomplete or invalid claim (hardcopy or electronic) will be "returned as unprocessable" or "returned to provider" (RTP) by the carrier or FI, respectively. The carrier or FI shall not deny claims and afford appeal rights for incomplete or invalid information as specified in this instruction. (See §80.3.1 for Definitions.)

If a data element is required and it is not accurately entered in the appropriate field, the carrier or FI returns the claim to the provider of service.

- If a data element is required, or is conditional (a data element that is required when certain conditions exist) and the conditions of use apply) and is missing or not accurately entered in its appropriate field, return as unprocessable or RTP the claim to either the supplier or provider of service.

- If a claim must be returned as unprocessable or RTP for incomplete or invalid information, the carrier or FI must, at minimum, notify the provider of service of the following information:

    - Beneficiary's Name;

    - Claim Number; HIC Number or HICN or Health Insurance Claim Number. This has never been HI Claim Number.

    - Dates of Service (MMDDCCYY) (Eight-digit date format effective as of October 1, 1998);

    - Patient Account or Control Number (only if submitted);

    - Medical Record Number (FIs only, if submitted); and

    - Explanation of Errors (e.g., Remittance Advice Reason and Remark Codes)

NOTE: Some of the information listed above may in fact be the information missing from the claim. If this occurs, the carrier or FI includes what is available.

Depending upon the means of return of a claim, the supplier or provider of service has various options for correcting claims returned as unprocessable or RTP for incomplete or invalid information. They may submit corrections either in writing, on-line, or via telephone when the claim was suspended for development, or submit as a "corrected" new claim, or as an entirely new claim if data from the original claim was not retained in the system, as with a front-end

return, or if a remittance advice was used to return the claim. The chosen mode of submission, however, must be currently supported and appropriate with the action taken on the claim.

NOTE: The supplier or provider of service must not be denied any services (e.g., modes of submission or customer service), other than a review, to which they would ordinarily have access.

- If a claim or a portion of a claim is "returned as unprocessable" or RTP for incomplete or invalid information, the carrier or FI does not generate an MSN to the beneficiary.

- The notice to the provider or supplier will not contain the usual reconsideration notice, but will show each applicable error code or equivalent message.

- If the carrier or FI uses an electronic or paper remittance advice notice to return an unprocessable claim, or a portion of unprocessable claim:

    1. The remittance advice must demonstrate all applicable error codes. However, there must be a minimum of two codes on the remittance notice (including code MA130).

    2. The returned claim or portion must be stored and annotated, as such, in history, if applicable. If contractors choose to suspend and develop claims, a mechanism must be in place where the carrier or FI can re-activate the claim or portion for final adjudication.

A. Special Considerations

- If a "suspense" system is used for incomplete or invalid claims, the carrier or FI will not deny the claim with appeal rights if corrections are not received within the suspense period, or if corrections are inaccurate. The carrier must return the unprocessable claim through the remittance process, without offering appeal rights, to the provider of service or supplier. The FI uses the RTP process.

- For assigned and unassigned claims submitted by beneficiaries (Form CMS-1490S), that are incomplete or contain invalid information, contractors shall manually return the claims to the beneficiaries. Contractors shall send a letter to the beneficiary with information explaining which information is missing, incorrect or invalid; information explaining the mandatory claims filing requirements; instructions for resubmitting the claim if the provider or supplier refuses to file the claim; and shall include language encouraging the beneficiary to seek non-emergency care from a provider or supplier that is enrolled in the Medicare program. Contractors shall also notify the provider or supplier about his/her obligation to submit claims on behalf of Medicare beneficiaries and that providers and suppliers are required to enroll in the Medicare program to receive reimbursement.

  Contractors shall consider a complete claim to have all items on the Form CMS-1490S completed along with an itemized bill with the following information: date of service, place of service, description of each surgical or medical service or supply furnished;

charge for each service; treating doctor's or supplier's name and address; diagnosis code; procedure code and the provider or supplier's National Provider Identifier. Required information on a claim must be valid for the claim to be considered as complete.

If a beneficiary submits a claim on the Form CMS-1500, return the Form CMS-1500 claim to the beneficiary, and include a copy of the Form CMS-1490S, along with a letter instructing the beneficiary to complete and return the Form CMS-1490S for processing within the time period prescribed in §70.5 above. Include in the letter a description of missing, invalid or incomplete items required for the Form CMS-1490S that were not included with the submitted Form CMS-1500 or were invalid.

NOTE: Telephone inquiries are encouraged.

- The carrier or FI shall not return an unprocessable claim if the appropriate information for both "required" and "conditional" data element requirements other than an NPI when the NPI is effective is missing or inaccurate but can be supplied through internal files. Contractors shall not search their internal files if an NPI is missing or inaccurate. Contractors shall not search their internal files to correct missing or inaccurate "required" and "conditional" data elements required under Sections 80.3.2.1.1 through 80.3.2.1.3 and required for HIPAA compliance for claims governed by HIPAA.

- For either a paper or electronic claim, if all "required" and "conditional" claim level information that applies is complete and entered accurately, but there are both "clean" and "dirty" service line items, then split the claim and process the "clean" service line item(s) to payment and return as unprocessable the "dirty" service line item(s) to the provider of service or supplier**. NOTE:** This requirement applies to carriers only.

No workload count will be granted for the "dirty" service line portion of the claim returned as unprocessable. The "clean" service line portion of the claim may be counted as workload **only if it is processed through the remittance process**. Contractors must abide by the specifications written in the above instruction; return the "dirty" service line portion without offering appeal rights.

- Workload will be counted for claims returned as unprocessable through the remittance process. Under no circumstances should claims returned as unprocessable by means other than the remittance process (e.g., claims returned in the front-end) be reported in the carrier or FI workload reports submitted to CMS. The carrier or FI is also prohibited from moving or changing the action on an edit that will result in an unprocessable claim being returned through the remittance process. If the current action on an edit is to suspend and develop, reject in the front or back-end, or return in the mailroom, the carrier or FI must continue to do so. Workload is only being granted to accommodate those who have edits which currently result in a denial. As a result, workload reports should not deviate significantly from those reports prior to this instruction.

NOTE: Rejected claims are not counted as an appeal on resubmissions.

B. Special Reporting of Unprocessable Claims Rejected through the Remittance Process (Carriers Only):

Carriers must report "claims returned as unprocessable on a remittance advice" on line 15 (Total Claims Processed) and on line 14 (subcategory Non-CWF Claims Denied) of page one of your Form CMS-1565. Although these claims are technically not denials, line 14 is the only suitable place to report them given the other alternatives. In addition, these claims should be reported as processed "not paid other" claims on the appropriate pages (pages 2-9) of CROWD Form T for the reporting month in which the claims were returned as unprocessable through the remittance process. Also, carriers report such claims on Form Y of the Contractor Reporting of Operational and Workload Data (CROWD) system. They report the "number of such claims returned during the month as unprocessable through the remittance process" under Column 1 of Form Y on a line using code "0003" as the identifier.

If a supplier, physician, or other practitioner chooses to provide missing or invalid information for a suspended claim by means of a telephone call or in writing (instead of submitting a new or corrected claim), carriers do not report this activity as a claim processed on Form CMS-1565/1566. Instead, they subtract one claim count from line 3 of Form Y for the month in which this activity occurred.

EXAMPLE: Assume in the month of October 2001 the carrier returned to providers 100 claims as unprocessable on remittance advices. The carrier should have included these 100 claims in lines 14 and 15 of page 1 of your October 2001 Form CMS-1565. During this same month, assume the carrier received new or corrected claims for 80 of the 100 claims returned during the month. These 80 claims should have been counted as claims received in line 4 of your October 2001 Form CMS-1565 page one (and subsequently as processed claims for the reporting month when final determination was made).

Also, during October 2001, in lieu of a corrected claim from providers, assume the carrier received missing information by means of a telephone call or in writing for 5 out of the 100 claims returned during October 2001. This activity should not have been reported as new claims received (or subsequently as claims processed when adjustments are made) on Form CMS-1565. On line 3 of Form Y for October 2001, the carrier should have reported the number 95 (From claims returned as unprocessable through the remittance process minus 5 claims for which the carrier received missing or invalid information by means of a telephone call or in writing.

For the remaining 15 claims returned during October 2001 with no response from providers in that same month, the carrier should have reported on the Form CMS-1565 or Form Y, as appropriate, any subsequent activity in the reporting month that it occurred. For any of these returned claims submitted as new or corrected claims, the carrier should have reported their number as receipts on line 4 of page one of Form CMS-1565. For any of these returned claims where the supplier or provider of service chose to supply missing or invalid information by means of a telephone call or in writing, the carrier should not have counted them again on Form CMS-1565, but subtracted them from the count of returned claims reported on line 3 of Form Y for the month this activity occurred.

C. Exceptions (Carrier Only)

The following lists some exceptions when a claim may not be "returned as unprocessable" for incomplete or invalid information.

Carriers shall not return a claim as unprocessable:

If a patient, individual, physician, supplier, or authorized person's signature is missing, but the signature is on file, or if the applicable signature requirements have been met, do not return a claim as unprocessable where an authorization is attached to the claim or if the signature field has any of the following statements (unless an appropriate validity edit fails):

Acceptable Statements for Form CMS-1500:

- For items 12, 13, and 31, "Signature on File" statement and/or a computer generated signature;

- For items 12 and 13, Beneficiary's Name "By" Representative's Signature;

For item 12, "X" with a witnessed name and address. (Chapter 26 for instructions.)

80.3.2.1 - Data Element Requirements Matrix
(Rev. 1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

The matrix (See Exhibit 1) specifies data elements, which are required, not required, and conditional for FI claims. The matrix does not specify item or field/record content and size. Refer the electronic billing instructions (UB-04 and ANSI 837) on the CMS Web site to build these additional edits. If a claim fails any one of these "content" or "size" edits, the FI returns the unprocessable claim to the supplier or provider of service.

The FIs must provide a copy of the matrix listing the data element requirements, and attach a brief explanation to providers of service and suppliers. The matrix is not a comprehensive description of requirement that need to be met in order to submit a compliant transaction.

80.3.2.1.1 - Carrier Data Element Requirements
(Rev. 1432, Issued: 02-01-08, Effective: 05-23-08, Implementation: 04-07-08)

A - Required Data Element Requirements

1 - Paper Claims

The following instruction describes certain data element formatting requirements to be followed when reporting the calendar year date for the identified items on the Form CMS-1500:

- If birth dates are furnished in the items stipulated below, then these items must contain 8-digit birth dates (MMDDCCYY). This includes 2-digit months (MM) and days (DD), and 4-digit years (CCYY).

Form CMS-1500 Items Affected by These Reporting Requirements:

Item 3 - Patient's Birth Date

Item 9b - Other Insured's Date of Birth

Item 11a - Insured's Date of Birth

Note that 8-digit birth dates, when provided, must be reported with a space between month, day, and year (i.e., MM_DD_CCYY). On the Form CMS-1500, the space between month, day, and year is delineated by a dotted, vertical line.

If a birth date is provided in items 3, 9b, or 11a, and is not in 8-digit format, carriers must return the claim as unprocessable. Use remark code N329 on the remittance advice. For formats other than the remittance, use code(s)/messages that are consistent with the above remark codes.

If carriers do not currently edit for birth date items because they obtain the information from other sources, they are not required to return these claims if a birth date is reported in items 3, 9b, or 11a. and the birth date is not in 8-digit format. However, if carriers use date of birth information on the incoming claim for processing, they must edit and return claims that contain birth date(s) in any of these items that are not in 8-digit format.

For certain other Form CMS-1500 conditional or required date items (items 11b, 14, 16, 18, 19, or 24A.), when dates are provided, either a 6-digit date or 8-digit date may be provided.

If 8-digit dates are furnished for any of items 11a., 14, 16, 18, 19, or 24A. (excluding items 12 and 31), carriers must note the following:

- All completed date items, except item 24A., must be reported with a space between month, day, and year (i.e., MM_DD_CCYY). On the Form CMS-1500, the space between month, day, and year is delineated by a dotted, vertical line;

- Item 24A. must be reported as one continuous number (i.e., MMDDCCYY), without any spaces between month, day, and year. By entering a continuous number, the date(s) in item 24A. will penetrate the dotted, vertical lines used to separate month, day, and year. Carrier claims processing systems will be able to process the claim if the date penetrates these vertical lines. However, all 8-digit dates reported must stay within the confines of item 24A;

- Do not compress or change the font of the "year" item in item 24A. to keep the date within the confines of item 24A. If a continuous number is furnished in item 24A. with no spaces between month, day, and year, you will not need to compress the "year" item to remain within the confines of item 24A.;

- The "from" date in item 24A. must not run into the "to" date item, and the "to" date must not run into item 24B.;

- Dates reported in item 24A. must not be reported with a slash between month, day, and year; and

- If the provider of service or supplier decides to enter 8-digit dates for any of items 11b, 14, 16, 18, 19, or 24A. (excluding items 12 and 31), an 8-digit date must be furnished for all completed items. For instance, you cannot enter 8-digit dates for items 11b, 14, 16, 18, 19 (excluding items 12 or 31), and a 6-digit date for item 24A. The same applies to those who wish to submit 6-digit dates for any of these items.

Carriers must return claims as unprocessable if they do not adhere to these requirements.

2 - Electronic Claims

Carriers must return all electronic claims that do not include an 8-digit date (CCYYMMDD) when a date is reported. They use remark code N329 on the remittance advice. For formats other than the remittance, carriers use code(s)/message(s) that are consistent with the above remark codes.

If carriers do not currently edit for birth date items because they obtain the information from other sources, they are not required to return these claims if a birth date is reported in items 3, 9b., or 11a. and the birth date is not in 8-digit format. However, if carriers do use date of birth information on the incoming claim for processing, they must edit and return claims that contain birth date(s) in any of these items that are not in 8-digit format.

B - Required Data Element Requirements

The following Medicare-specific, return as unprocessable requirements in this section and the following two sections are in addition to requirements established under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Regulations implementing HIPAA require the use of National Provider Identifiers (NPIs) by covered health care providers and health plans. Although not required by HIPAA, CMS is extending the requirement to include the NPI on electronic claims to paper claims submitted on the Form CMS-1500 (8/05). Carriers are referred to the Health Care Claims Professional 837 Implementation guide for requirements for professional claims subject to HIPAA, including the NPI reporting requirements.

Carriers must return a claim as unprocessable to a provider of service or supplier and use the indicated remark code, or select and use another appropriate remark code, if the claim is returned through the remittance advice or notice process. In most cases, reason code 16, "Claim/service lacks information that is needed for adjudication", will be used in tandem with the appropriate remark code that specifies the missing information.
Carriers shall return a claim as unprocessable:

1. If a claim lacks a valid Medicare Health Insurance Claim Number (HICN) in item 1a. or contains an invalid HICN in item 1a. (Remark code MA61.)

2. If a claim lacks a valid patient's last and first name as seen on the patient's Medicare card or contains an invalid patient's last and first name as seen on the patient's Medicare card. (Remark code MA36.)

3. If a claim does not indicate in item 11 whether or not a primary insurer to Medicare exists. (Remark code MA83 or MA92.)

4. If a claim lacks a valid patient or authorized person's signature in item 12 or contains an invalid patient or authorized person's signature in item 12. (See "Exceptions," bullet number one. Remark code MA75.)

5. If a claim lacks a valid "from" date of service in item 24A or contains an invalid "from" date of service in item 24A. (Remark code M52.)

6. If a claim lacks a valid place of service (POS) code in item 24B., or contains an invalid POS code in item 24B. return the claim as unprocessable to the provider or supplier, using RA remark code M77. Effective for claims received on or after April 1, 2004, on the Form CMS-1500, if a claim contains more than one POS (other than Home – 12), for services paid under the MPFS and anesthesia services.

7. If a claim lacks a valid procedure or HCPCS code (including Levels 1-3, "unlisted procedure codes," and "not otherwise classified" codes) in item 24D or contains an invalid or obsolete procedure or HCPCS code (including Levels 1-3, "unlisted procedure codes," and "not otherwise classified" codes) in item 24D. (Remark code M20 or M51.)

NOTE: Level 3 HCPCS are not valid under HIPAA after Dec 31, 2003.

8. If a claim lacks a charge for each listed service. (Remark code M79.)

9. If a claim does not indicate at least 1 day or unit in item 24G (Remark Code M53.) (Note: To avoid returning the claim as "unprocessable" when the information in this item is missing, the carrier must program the system to automatically default to "1" unit).

10. If a claim lacks a signature from a provider of service or supplier, or their representative. (See "Exceptions," bullet number one; Remark code MA70 for a missing provider representative signature, or code MA81 for a missing physician/supplier/practitioner signature.)

11. If a claim does not contain in item 33:

a. A billing name, address, ZIP Code, and telephone number of a provider of service or supplier. (Remark code N256 or N258.)

AND EITHER

b. A valid PIN number or, for DMERC claims, a valid National Supplier Clearinghouse number (NPI in item 33a. of the Form CMS-1500 (8/05) when the NPI is required) for the performing provider of service or supplier who is not a member of a group practice. (Remark code N257)

OR

c. A valid group PIN (or NPI when required) number or, for DMERC claims, a valid National Supplier Clearinghouse number (NPI in item 33a. of the Form CMS-1500

(8/05), when the NPI is required) for performing providers of service or suppliers who are members of a group practice. (Remark code N257)

12. If a claim does not contain in Item 33a., Form CMS 1500 (08-05), the NPI, when required, of the billing provider, supplier, or group. (Remark Code N257 or MA112.)

13. Effective May 23, 2008, if a claim contains a legacy provider identifier, e.g., PIN, UPIN, or National Supplier Clearinghouse number. (Remark Code N 257)

NOTE: Claims are not to be returned as unprocessable in situations where an NPI is not required (e.g., foreign claims, deceased provider claims, other situations as allowed by CMS in the future) and legacy numbers are reported on the claim. Such claims are to be processed in accordance with the established procedures for these claims.

80.3.2.1.2 - Conditional Data Element Requirements for Carriers and DMERCs

(Rev. 1589, Issued: 09-08-08, Effective: 12-08-08, Implementation: 12-08-08)

A - Universal Requirements

The following instruction describes "conditional" data element requirements, which are applicable to assigned carrier claims. This instruction is minimal and does not include all "conditional" data element requirements, which are universal for processing claims. The CMS has specified which remark code(s) should be used when a claim fails a particular "return as unprocessable" edit and a remittance advice is used to return the claim. In addition to the specified remark code(s), carriers must include Remark Code MA130 on returned claim(s). Reason code(s) must also be reported on every remittance advice used to return a claim or part of a claim as unprocessable.

Items from the Form CMS-1500 (hardcopy) have been provided. These items are referred to as fields in the instruction.

Carriers must return a claim as unprocessable to the supplier/provider of service in the following circumstances:

a. If a service was ordered or referred by a physician, physician assistant, nurse practitioner, or clinical nurse specialist (other than those services specified in Claim Specific Requirements) and his/her name and/or NPI is not present in item 17 or 17a. or if the NPI is not entered in item 17b. of the Form CMS-1500 (8/05). (Remark code N285 or N286 is used)

b. If a physician extender or other limited licensed practitioner refers a patient for consultative services, but the name and/or NPI is required of the supervising physician is not entered in items 17 or 17a. or if the NPI is not entered in item 17b. of the CMS-1500 (8/05). (Remark code N269 or N270 is used.)

c. For diagnostic tests subject to purchase price limitations:

1. If a “YES” or “NO” is not indicated in item 20. Carriers/AB MACs shall assume the service is not purchased. This claim shall not be returned as unprocessable for this reason only.

2. If the “YES” box is checked in item 20 and a required purchase price is not entered under the word “$CHARGES.” (Remark code MA111 is used.)

3. If the “YES” box is checked in item 20 and the purchase price is entered under “$CHARGES", but the supplier’s name, address, ZIP Code, the NPI is not entered into item 32a of the Form CMS-1500 (8/05) when billing for purchased diagnostic tests. (Remark code N256, N257, or N258 are used.)

Entries 4 – 8 are effective for claims received on or after April 1, 2004:

4. On the Form CMS-1500, if the “YES” box is checked in Item 20, and more than one test is billed on the claim;

5. On the Form CMS-1500, if both the interpretation and test are billed on the same claim and the dates of service and places of service do not match;

6. On the Form CMS-1500, if the “YES” box is checked in Item 20, both the interpretation and test are submitted and the date of service and place of service codes do not match.

7. On the ANSI X12N 837 electronic format, if there is an indication on the claim that a test has been purchased, more than one test is billed on the claim, and line level information for each total purchased service amount is not submitted for each test.

8. On the Form CMS-1500 if the “YES” box is checked in Item 20 and on the ANSI X12N 837 electronic format if there is an indication on the claim that a test has been purchased, and the service is billed using a global code rather than having each component billed as a separate line item.

d. If a provider of service or supplier is required to submit a diagnosis in item 21 and either an ICD-9CM code is missing, incorrect or truncated; or a narrative diagnosis was not provided on an attachment. (Remark code M81 or M76 are used.)

e. If modifiers “QB” and “QU” or, effective on or after January 1, 2006, the modifier "AQ" are entered in item 24D indicating that the service was rendered in a Health Professional Shortage Area, but where the place of service is other than the patient’s home or the physician’s office, the name, address, and ZIP Code of the facility where the services were furnished are not entered in item 32. (Remark code MA115 is used.) Effective for claims received on or after April 1, 2004, the name, address, and ZIP Code of the service location for all services other than those furnished in place of service home – 12 must be entered.

f. If a rendering physician, physician assistant, nurse practitioner, clinical nurse specialist, supplier/or other practitioner who is a sole practitioner or is a member of a group practice does not enter his/her NPI into item 24J of Form CMS-1500 (08-05) except for influenza

virus and pneumococcal vaccine claims submitted on roster bills that do not require a rendering provider NPI. (Remark code N290 is used.)

g. If a primary insurer to Medicare is indicated in item 11, but items 4, 6, and 7 are incomplete. (Remark code(s) MA64, MA88, MA89, or MA92 as appropriate for the missing piece(s) of data are used.)

h. If there is insurance primary to Medicare that is indicated in item 11 by either an insured/group policy number or the Federal Employee Compensation Act number, but a Payer or Plan identification number (use PlanID when effective) is not entered in field 11C, or the primary payer's program or plan name when a Payer or Plan ID (use PlanID when effective) does not exist. (Remark code MA92 or N245 is used.)

i. If a HCPCS code modifier must be associated with a HCPCS procedure code or if the HCPCS code modifier is invalid or obsolete. (Remark code M20 if there is a modifier but no HCPCS.)

j. If a date of service extends more than 1 day and a valid "to" date is not present in item 24A. (Remark code M59 is used.)

k. If an "unlisted procedure code" or a "not otherwise classified" (NOC) code is indicated in item 24D, but an accompanying narrative is not present in item 19 or on an attachment. (Remark code M51 is used.)

l. If the name, address, and ZIP Code of the facility where the service was furnished in a hospital, clinic, laboratory, or facility other than the patient's home or physician's office is not entered in item 32 (Remark code MA114 is used.) Effective for claims received on or after April 1, 2004, the name, address, and ZIP Code of the service location for all services other than those furnished in place of service home – 12 must be entered. (Remark code MA114 is used.)

Effective for claims with dates of service on or after October 1, 2007, the name, address, and 9-digit ZIP Code of the service location for services paid under the Medicare Physician Fee Schedule and anesthesia services, other than those furnished in place of service home – 12, and any other places of service contractors treat as home, must be entered according to Pub. 100-04, Chapter 1, sections 10.1.1 and 10.1.1.1. (Remark code MA114 is used.)

Effective for claims with dates of service on or after October 1, 2007, for claims received that require a 9-digit ZIP Code with a 4 digit extension, a 4-digit extension that matches one of the ZIP9 file or a 4-digit extension that can be verified according to Pub. 100-04, Chapter 1, sections 10.1.1 and 10.1.1.1 must be entered on the claim. (Remark code MA114 is used.)

m Effective for claims received on or after April 1, 2004, if more than one name, address, and ZIP Code is entered on the Form CMS-1500 (08-05) in item 32.

80.3.2.1.3 - Carrier Specific Requirements for Certain Specialties/Services

(Rev. 1690; Issued: 02-27-09; Effective/Implementation Date: 03-27-09)

Carriers must return the following claim as unprocessable to the provider of service/supplier:

a. For chiropractor claims:

1. If the x-ray date is not entered in item 19 for claims with dates of service prior to January 1, 2000. Entry of an x-ray date is not required for claims with dates of service on or after January 1, 2000.

2. If the initial date "actual" treatment occurred is not entered in item 14. (Remark code MA122 is used.)

b. For certified registered nurse anesthetist (CRNA) and anesthesia assistant (AA) claims, if the CRNA or AA is employed by a group (such as a hospital, physician, or ASC) and the group's name, address, ZIP Code, and PIN number, until the NPI is required, is not entered in item 33 or if the NPI is not entered in item 33a.of the Form CMS-1500 (8/05) when the NPI is required or, until the NPI is required, if their personal PIN is not entered in item 24K of the Form CMS-1500 (12-90) or if the NPI is not entered into item 24J of the Form CMS-1500 (8/05) when the NPI is required. (Remark code MA112 is used.)

c. For durable medical, orthotic, and prosthetic claims, if the name, address, and ZIP Code of the location where the order was accepted were not entered in item 32. (Remark code MA 114 is used.)

d. For physicians who maintain dialysis patients and receive a monthly capitation payment:

1. If the physician is a member of a professional corporation, similar group, or clinic, and, until the NPI is required, the attending physician's PIN is not entered in item 24K of the Form CMS-1500 (12-90) or if the NPI is not entered into item 24J of the Form CMS-1500 (8/05) when the NPI is required). (Remark code N290 is used.)

2. If the name, address, and ZIP Code of the facility other than the patient's home or physician's office involved with the patient's maintenance of care and training is not entered in item 32. (Remark code MA114 is used.) Effective for claims received on or after April 1, 2004, the name, address, and ZIP Code of the service location for all services other than those furnished in place of service home – 12 must be entered.

e. For routine foot care claims, if the date the patient was last seen and the attending physician's PIN (or NPI when required) is not present in item 19. (Remark code N324 or N253 is used.)

f. For immunosuppressive drug claims, if a referring/ordering physician, physician's assistant, nurse practitioner, clinical nurse specialist was used and their name is not present in items 17 or their UPIN (until the NPI is required) is not present in 17a. or if the NPI is not entered in item 17b. of the Form CMS-1500 (8/05) when the NPI is required. (Remark code N264 or N286 is used.)

g. For all laboratory services, if the services of a referring/ordering physician, physician's assistant, nurse practitioner, clinical nurse specialist are used and his or her name is not present in items 17 or their UPIN (until the NPI is required) is not present in 17a. or if the NPI is not

entered in item 17b. of the Form CMS-1500 (8/05) when the NPI is required. (Remark code N264 or N286 is used.)

h. For laboratory services performed by a participating hospital-leased laboratory or independent laboratory in a hospital, clinic, laboratory, or facility other the patient's home or physician's office (including services to a patient in an institution), if the name, address, and ZIP Code of the location where services were performed is not entered in item 32. (Remark code MA114 is used.) Effective for claims received on or after April 1, 2004, the name, address, and ZIP Code of the service location for all services other than those furnished in place of service home – 12 must be entered.

i. For independent laboratory claims:

1. Involving EKG tracing and the procurement of specimen(s) from a patient at home or in an institution, if the claim does not contain a validation from the prescribing physician that any laboratory service(s) performed were conducted at home or in an institution by entering the appropriate annotation in item 19 (i.e., "Homebound"). (Remark code MA116 is used.)

2. If the name, address, and ZIP Code where the test was performed is not entered in item 32, if the services were performed in a location other than the patient's home or physician's office. (Remark code MA114 is used.) Effective for claims received on or after April 1, 2004, the name, address, and ZIP Code of the service location for all services other than those furnished in place of service home – 12 must be entered.

3. When a diagnostic service is billed as a purchased service and the service is purchased from another billing jurisdiction, the billing provider must submit their own NPI in Item 32a with the name, address, and ZIP Code of the performing provider in Item 32. If Item 32 and 32a are not entered, remark code MA114 is used.

j. For mammography "diagnostic" and "screening" claims, if a qualified screening center does not accurately enter their 6-digit, FDA-approved certification number in item 32 when billing the technical or global component. (Remark code MA128 is used.)

k. For parenteral and enteral nutrition claims, if the services of an ordering/referring physician, physician assistant, nurse practitioner, clinical nurse specialist are used and their name is not present in item 17 or their UPIN (until the NPI is required) is not present in item 17a. or if the NPI is not entered in item 17b.of the Form CMS-1500 (8/05) when the NPI is required). (Remark code N264 or N286 is used.)

l. For portable x-ray services claims, if the ordering physician, physician assistant, nurse practitioner, clinical nurse specialist's name, and/or UPIN (or NPI when required) is not entered in items 17 or their UPIN (until the NPI is required) is not entered in item 17a. or if the NPI is not entered in item 17b. of the Form CMS-1500 (8/05) when the NPI is required). (Remark code N264 or N286 is used.)

m. For radiology and pathology claims for hospital inpatients, if the referring/ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist's name, if

appropriate, is not entered in items or 17 or their UPIN (until the NPI is required) is not entered in item 17a. or if the NPI is not entered in item 17b. of the Form CMS-1500 (8/05) when the NPI is required. (Remark code N264 or N286 is used.)

n. For outpatient physical or occupational therapy services provided by a qualified, independent physical, or occupational therapist, Medicare policy does not require the date last seen by a physician, or the UPIN or NPI, when required, of such physician. Medicare policy does not require identification of the ordering, referring or certifying physician on outpatient therapy claims, including speech-language pathology service claims. However, providers and suppliers are required to comply with applicable HIPAA ASC X12 837 claim completion requirements. See Pub. 100-04, chapter 5, §20 and Pub. 100-02, chapter 15, §§220 and 230 for therapy service policies. Deletion of this claim requirement for outpatient therapy services does not apply to the requirements for the date last seen and the UPIN or NPI, when required, of the ordering and supervising physician/nonphysician practitioner for therapy services provided incident to the services of a physician, because the incident to policies continue to require them.

1. If the UPIN (or NPI when required) of the attending physician is not present in item 19. (Remark code N253 is used.)

2. If the 6-digit (MM | DD | YY) or 8-digit (MM | DD | CCYY) date patient was last seen by the attending physician is not present in item 19. (Remark code N324 is used.)

o. For all laboratory work performed outside a physician's office, if the claim does not contain a name, address, and ZIP Code, and PIN (until the NPI is required) where the laboratory services were performed in item 32 or if the NPI is not entered into item 32a. of the Form CMS-1500 (8/05) when the NPI is required), if the services were performed at a location other than the place of service home – 12. (Use Remark code MA114.)

p. For all physician office laboratory claims, if a 10-digit CLIA laboratory identification number is not present in item 23. This requirement applies to claims for services performed on or after January 1, 1998. (Remark code MA120 is used.)

q. For investigational devices billed in an FDA-approved clinical trial if an Investigational Device Exemption (IDE) number is not present in item 23, for dates of service through March 31, 2008. (Remark code MA50 is used.) With the use of new modifier Q0, effective for dates of service on and after April 1, 2008, contractors will no longer be able to distinguish an IDE claim from other investigational clinical services. Therefore this edit will no longer apply.

r. For physicians performing care plan oversight services if the 6-digit Medicare provider number of the home health agency (HHA) or hospice is not present in item 23. (Remark code MA49 is used.)

s. For Competitive Acquisition Program drug and biological claims, in accordance with the instructions found in the Medicare Claims Processing Manual, chapter 17, section 100.2.1 – section 100.9.

t. For claims for artificial hearts covered by Medicare under an approved clinical trial, if procedure code 0051T is entered in Item 24D, and an 8-digit clinical trial number that matches

an approved clinical trial listed at: http://www.cms.hhs.gov/MedicareApprovedFacilitie/06_artificialhearts.asp#TopOfPage is not entered in Item 19; and the HCPCS modifier Q0 is not entered on the same line as the procedure code in Item 24D, and the diagnosis code V70.7 is not entered in Item 21 and linked to the same procedure code. (As appropriate, use remark code MA97 – Missing/ incomplete/invalid Medicare Managed Care Demonstration contract number or clinical trial registry number; M64 – Missing/incomplete/invalid other diagnosis; or claim adjustment reason code 4 - The procedure code is inconsistent with the modifier used or a required modifier is missing.)

80.3.2.2 - FI Consistency Edits

(Rev. 1065, Issued: 09-22-06, Effective: 08-01-00; Implementation: 04-03-06)

In order to be processed correctly and promptly, a bill must be completed accurately. FIs edit all Medicare required fields as shown below. If a bill fails these edits, FIs return it to the provider for correction. If bill data is edited online, the edits are included in the software. When FIs receive magnetic tape or paper bills, either directly or through a billing service, they must ensure that these edits are made. Depending upon special services billed, FIs may require additional edits.

FL 4. Type of Bill

a. Must not be spaces.

b. Must be a valid code for billing. Valid codes are:

First Digit - Type of Facility:

1 - Hospital

NOTE: Hospital-based multi-unit complexes may also have use for the following first digits when billing non-hospital services:

2 - Skilled Nursing

3 - Home Health

4 - Religious Non-Medical (Hospital)

7 - Clinic or Renal Dialysis Facility (requires special information in second digit below)

8 - Special Facility or Hospital ASC Surgery (requires special information in second digit, see below)

Second Digit - Classification (if first digit is 1-5):

1 - Inpatient (Part A)

2 - Hospital-Based or Inpatient (Part B) (includes HHA visits under a Part B plan of treatment)

3 - Outpatient (includes HHA visits under a Part A plan of treatment and use of HHA DME under a Part A plan of treatment)

4 - Other (Part B) (includes HHA medical and other health services not under a plan of treatment, hospital and SNF for diagnostic clinical laboratory services for "nonpatients")

8 - Swing bed (used to indicate billing for SNF level of care in a hospital with an approved swing bed agreement)

Second Digit - Classification (first digit is 7):

1 - Rural Health Clinic (RHC)

2 - Hospital-Based or Independent Renal Dialysis Facility

3 - Free-Standing Provider-Based Federally Qualified Health Center (FQHC)

4 - Other Rehabilitation Facility (ORF)

5 - Comprehensive Outpatient Rehabilitation Facility (CORF)

6 - Community Mental Health Center (CMHC)

Second Digit - Classification (first digit is 8):

1 - Hospice (Nonhospital-based)

2 - Hospice (Hospital-based)

3 - Ambulatory Surgical Center Service to Hospital Outpatients

4 - Free Standing Birthing Center

5 - Critical Access Hospital (CAH)

Third Digit - Frequency:

A - Admission/Election Notice

B - Hospice/Medicare Coordinated Care Demonstration/Religious Non-Medical Health Care Institution-Termination/Revocation Notice

C - Hospice Change of Provider

D - Hospice/Medicare Coordinated Care Demonstration/Religious Non-Medical Health Care Institution-Void/Cancel

E - Hospice Change of Ownership

F - Beneficiary Initiated Adjustment Claim (For FI use only)

G - CWF Initiated Adjustment Claim (For FI use only)

H - CMS initiated Adjustment Claim (For FI use only)

I - FI Adjustment Claim (Other than QIO or Provider) (For FI use only)

J - Initiated Adjustment Claim-Other (For FI use only)

K - OIG Initiated Adjustment Claim (For FI use only)

M - MSP Initiated Adjustment Claim (For FI use only)

P - QIO Adjustment Claim (For FI use only)

0 - Nonpayment/zero claims

1 - Admit Through Discharge Claim

2 - Interim - First Claim

3 - Interim – Continuing Claims (Not valid for PPS bills. Exception: SNF PPS bills)

4 - Interim – Last Claim (Not valid for PPS bills. Exception: SNF PPS bills)

5 - Late charge

7 - Correction

8 - Void/Cancel

9 - Final Claim for a Home Health PPS Episode

FL 6. Statement Covers Period (From - Through)

a. Cannot exceed eight positions in either “From” or “Through” portion allowing for separations (nonnumeric characters) in the third and sixth positions.

b. The “From” date must be a valid date that is not later than the “Through” date.

c. The “Through” date must be a valid date that is not later than the current date.

d. The number of days represented by this period must equal the sum of the covered days (FL 7) and noncovered days (FL 8), if the type of bill is 11X, 18X, 21X, or 41X.

e. With the exception of Home Health PPS claims, the statement covers period may not span 2 accounting years.

FL 7. Covered Days

FIs do not need to edit the provider's bill. They determine the proper number of covered days in their bill process.

FL 8. Noncovered Days

FIs do not need to edit the provider's bill. They determine the proper number of noncovered days in their bill process.

FL 9. Coinsurance Days

FIs do not need to edit the provider's bill. They determine the proper number of coinsurance days in their bill process.

FL 10. Lifetime Reserve Days

FIs do not need to edit the provider's bill. They determine the proper number of lifetime reserve days in their bill process.

FL 13. Patient's Address

a. The address of the patient must include:

City
State (P.O. Code)
ZIP

b. Valid ZIP code must be present if the type of bill is 11X, 13X, 18X, or 83X or 85X.

c. Cannot exceed 62 positions.

FL 14. Birthdate

a. Must be valid if present.

b. Cannot exceed 10 positions allowing for separations (nonnumeric characters) in the third and sixth positions.

FL 15. Sex

a. One alpha position.

b. Valid characters are “M” or “F.”

c. Must be present.

FL 17. Admission Date

a. Must be valid if present.

b. Cannot exceed eight positions allowing for separations (nonnumeric characters) in the third and sixth positions.

c. Present only if the type of bill is 11X, 12X, 18X, 21X, 22X, 32X, 33X, 41X, 81X or 82X.

d. Cannot be later than the “From” portion of Item 6.

FL 19. Type of Admission/Visit

a. One numeric position.

b. Required only if the type of bill is 11X, 12X, 18X, 21X, 22X, or 41X.

c. Valid codes are located in Chapter 25.

FL 20. Source of Admission.

a. One numeric position

b. Must be present

c. Valid codes are located in Chapter 25.

FL 22. Patient Status.

a. Two numeric positions

b. Present on all Part A inpatient, SNF, hospice, home health agency, and outpatient hospital services. Types of bill: 11X, 12X, 13X, 14X, 18X, 21X, 22X, 23X, 32X, 33X, 34X, 41X, 71X, 73X, 74X, 75X, 76X, 81X, 82X, 83X, or 85X.

c. Valid codes are located in Chapter 25.

FL 23. Medical Record Number

a. If provided by the hospital, must be recorded by the FI for the QIO.

b. Must be left justified in CWF record for QIO.

FLs 24, 25, 26, 27, 28, 29, and 30. Condition Codes.

a. Each code is two numeric digits.

b. Valid codes are located in Chapter 25.

c. If code 07 is entered, type of bill must not be hospice 81X or 82X.

d. If codes 36, 37, 38, or 39 are entered, the type of bill must be 11X and the provider must be a non-PPS hospital or exempt unit.

e. If code 40 is entered, the "From" and "Through" dates in FL 6 must be equal, and there must be a "0" or "1" in FL 7 (Covered Days).

f. Only one code 70, 71, 72, 73, 74, 75, or 76 can be on an ESRD claim.

g. Code C1, C3, C4, C5, or C6 must be present if type of bill is 11X or 18X.

FLs 32, 33, 34, and 35. Occurrence Codes and Dates

a. All dates must be valid.

b. Each code must be accompanied by a date.

c. All codes are two alphanumeric positions.

d. Valid codes are located in Chapter 25.

e. If code 20 or 26 is entered, the type of bill must be 11X or 41X. If code 21 or 22 is entered, the type of bill must be 18X or 21X.

f. If code 27 is entered, the type of bill must be 81X or 82X.

g. If code 28 is entered, the first digit in FL 4 must be a "7" and the second digit a "5."

h. If code 42 is entered, the first digit in FL 4 must be "8" and the second digit "1" or "2" and the third digit "1 or 4."

i. If 01 - 04 is entered, Medicare cannot be the primary payer, i.e., Medicare-related entries cannot appear on the "A" lines of FLs 58-62.

j. If code 20 is entered:

- Must not be earlier than "Admission" date (FL 17) or later than "Through" date (FL 6).

- Must be less than 13 days after the admission date (FL 17) if "From" date is equal to admission date (less than 14 days if billing dates cover the period December 24 through January 2).

k. If code 21 is entered:

- Cannot be later than "Statement Covers Period" Through date; or
- Cannot be more than 3 days prior to the "Statement Covers Period" From date.

l. If code 22 is entered, the date must be within the billing period shown in FL 6.

m. If code 31 is entered, the type of bill must be 11X, 21X, or 41X.

n. If code 32 is entered, the type of bill must be 13X, 14X, 23X, 32X, 33X, 34X, 71X, 72X, 73X, 74X, 75X, 81X, or 82X.

FL 36. Occurrence Span Codes and Dates

a. Dates must be valid.

b. Code entry is two alphanumeric positions.

c. Code must be accompanied by dates.

d. Valid codes are located in Chapter 25.

e. If code 70 is entered, the type of bill must be 11X, 18X, 21X, or 41X.

f. If code 71 is entered, the first digit of FL 4 must be "1," "2," or "4" and the second digit must be "1."

g. If code 72 is entered, the type of bill must be 13X, 14X, 32X, 33X, 34X, 71X, 73X, 74X, or 75X.

h. If code 74 is entered, the type of bill must be 11X, 13X, 14X, 18X, 21X, 34X, 41X, 71X, 72X, 74X, 75X, 81X, or 82X.

i. If code 75 is entered, the first digit of FL 4 must be "1" or "4" and the second digit must be "1."

j. If code 76 is entered, occurrence code 31 must be present (inpatient only).

k. If code 76 is entered, occurrence code 32 must be present (outpatient only).

l. If code 76, 77, or M1 is present, the bill type must be 11X, 13X, 14X, 18X, 21X, 34X, 41X, 71X, 72X, 73X, 74X, 75X, 81X, 82X, or 85X.

m. Neither the “From” nor the “Through” portion can exceed eight positions allowing for separations (nonnumeric characters) in the third and sixth positions of each field.

n. If code M2 is present, the bill type must be 81X or 82X.

o. Code 79 is for payer use only. Providers do not report this code.

FLs 39, 40, and 41. Value Codes and Amounts.

a. Each code must be accompanied by an amount.

b. All codes are two alphanumeric digits.

c. Amounts may be up to ten numeric positions. (00000000.00)

d. Valid codes are located in Chapter 25.

e. If code 06 is entered, there must be an entry for code 37.

f. If codes 08 and/or 10 are entered, there must be an entry in FL 10.

g. If codes 09 and/or 11 are entered, there must be an entry in FL 9.

h. If codes 12, 13, 14, 15, 41, 43, or 47 are entered as zeros, occurrence codes 01, 02, 03, 04, or 24 must be present.

i. Entries for codes 37, 38, and 39 cannot exceed three numeric positions.

j. If the blood usage data is present, code 37 must be numeric and greater than zero.

FL 42. Revenue Codes.

a. Four numeric positions.

b. Must be listed in ascending numeric sequence except for the final entry, which must be “0001” for hardcopy claims only.

c. There must be a revenue code adjacent to each entry in FL 47.

d. For bill types 32X and 33X the following revenue codes require a 5-position HCPCS code:

0274, 029X, 042X, 043X, 044X, 055X, 056X, 057X, 0601, 0602, 0603, and 0604.

e. For bill type 34X, the following revenue codes require a 5-position HCPCS code:

0271-0274, 42X, 43X, 44X, and 0601-0604.

f. For bill type 21X, 32X, 33X, or 11X (IRF facilities) the following revenue codes require a 5-position HIPPS code:

0022 (SNF only), 0023 (HH only), 0024 (IRFs only).

FL 45. Service Date

a. Six numeric positions, MMDDYY.

b. A single line item date of service (LIDOS) is required on every revenue code present on types of bill 12X, 13X, 14X, 22X, 23X, 24X, 32X, 33X, 34X, 71X, 73X, 74X, 75X, 76X, 81X, 82X, and 83X.

Exception: LIDOS are not required for CAHs, Indian Health Service hospitals, and hospitals located in American Samoa, Guam, and Saipan.

c. When a particular service is rendered more than once during the billing period, the revenue code and HCPCS code must be entered separately for each service date.

FL 46. Units of Service

a. Up to seven numeric positions.

b. Must be present for all services with the exception of the HIPPS line item service. (Exception: Units are required on the HIPPS line for SNF claims)

c. Accommodation units must equal covered days (FL 7) with the exception of the R No-Pay.

FL 47. Total Charges

a. Up to 10 numeric positions (00000000.00).

b. There must be an entry adjacent to each entry in FL 42.

c. The “0001” amount must be the sum of all the entries for hardcopy only.

FLs 50A, B, and C. Payer Identification

a. "Medicare” must be entered on one of these lines depending upon whether it is the primary, secondary or tertiary payer.

b. If value codes 12, 13, 14, 15, 16, 41, 42, 43, or 47 are present, data pertaining to Medicare cannot be entered in Line A of FLs 50-62.

FL 51. Medicare Provider Number

a. A 6-position alpha/numeric field (for CMS use only, effective May 23, 2007, providers are required to submit only their NPI).

b. Left justified.

FLs 58A, B, and C. Insured's Name

a. Must be present. Cannot be all spaces.

FLs 60A, B, and C. Certificate/Social Security Number/HI Claim/Identification Number

a. Must be present.

b. Must contain nine numeric characters and at least one alpha character as a suffix. The first alpha suffix is entered in position 10, the second in position 11, etc. The first three numbers must fall within the range of 001 through 680 or 700 through 728.

c. The alpha suffix must be A through F, H, J, K, M, T, or W. Alpha suffixes A and T must not have a numeric subscript. Alpha suffixes B, C, D, E, F, M, and W may or may not have a numeric subscript.

d. If the alpha suffix is H, it must be followed by A, B or C in position eleven. The numeric subscript (position twelve) must conform with the above for the A, B, or C suffix to be used.

e. RRB claim numbers must contain either six or nine numeric characters, and must have one, two, or three character alpha prefix.

f. For prefixes H, MH, WH, WCH, PH and JA only a 6-digit numeric field is permissible. For all other prefixes, a six or nine numeric field is permissible.

g. Nine numeric character claim numbers must have the same ranges as the SSA 9-position claim numbers.

FL 67. Principal Diagnosis Code.

a. Must be four or five positions left justified with no decimal points. FIs validate with MCE and OCE programs.

b. Must be valid ICD-9-CM code.

FLs 68-75. Other Diagnosis Codes.

a. If present, must be four or five positions, left justified with no decimal points. FIs validate with MCE and OCE programs.

FL 80. Principal Procedure Code and Date

a. If present, must be valid ICD-9-CM procedure code. FIs validate with MCE program.

b. If code is present, date must be present and valid.

c. Date must fall before the "Through" date in FL 6. (In some cases it may be before the admission date, i.e., where complications and admission ensue from outpatient surgery.)

FL 81. Other Procedure Codes and Dates.

a. If present, apply edits for FL 80

FL 82. Attending/Referring Physician I.D.

- The UPIN must be present on inpatient Part A bills with a "Through" date of January 1, 1992, or later. For outpatient and other Part B services, the UPIN must be present if the "From" date is January 1, 1992, or later. This requirement applies to all provider types and all Part B bill types.
    - Number, last name, and first initial must be present;
    - First three characters must be alpha or numeric; and
    - If first three characters of UPIN are INT, RES, VAD, PHS, BIA, OTH, RET, or SLF, exit. Otherwise, the 4th through 6th positions must be numeric.

FL 83. Other Physician I.D

a. Must be present if:

- Bill type is 11X and a procedure code is shown in FLs 80-81;
- Bill type is 83X or 13X and a HCPCS code is reported that is subject to the ASC payment limitation or is on the list of codes the QIO furnishes that require approval; or
- Bill type is 85X and HCPCS code is in the range of 10000 through 69979.

b. If required:

- First three characters must be alpha or numeric:
- Number, last name and first initial must be present; and
- Left justified:

    If first three characters of UPIN are INT, RES, VAD, PHS, BIA, OTH, RET, or SLF, exit. Otherwise the 4th through 6th positions must be numeric.

80.3.3 - Timeliness Standards for Processing Other-Than-Clean Claims
(Rev. 1312, Issued: 07-20-07, Effective: 01-01-08, Implementation: 01-07-08)

The Social Security Act, at §1869(a)(2), mandates that Medicare process all "other-than-clean" claims and notify the individual filing such claims of the determination within 45 days of receiving such claims.

Claims that do not meet the definition of "clean" claims are "other-than-clean" claims. "Other-than-clean" claims require investigation or development external to the contractor's Medicare operation on a prepayment basis.

The contractor shall process all "other-than-clean" claims and notify the provider and provider of the determination within 45 calendar days of receipt. (See Pub100-4, Chapter 1, §80.2.1 for the definition of "receipt date" and for timeliness standards for clean claims.) However, when the contractor develops to the provider/supplier or beneficiary for additional information, the contractor shall cease counting the 45 calendar days on the day that the contractor sends the development letter. Upon receiving the materials requested in the development letter from the provider/supplier and/or beneficiary, the contractor shall resume counting the 45 calendar days.

EXAMPLE:

> The contractor receives a claim on June 1st, but does not send a development letter to the provider/supplier/ and/or beneficiary until June 5th. In this situation, 5 of the 45 allotted calendar days will have already passed before the contractor requested the additional information. Upon receiving the information back from the provider/supplier and/or beneficiary, the contractor has 40 calendar days left to process the claim and notify the individual that filed the claim of the payment determination for that claim.

Contractors shall follow existing procedures relative to both the length of time the provider/supplier and/or beneficiary is afforded to return information requested in the development letters and situations where the provider/supplier and or beneficiary does not respond.

Contractors shall report the number of other-than-clean claims processed in 45 days or less on Form Y of the Contractor Reporting of Operational and Workload Data (CROWD) report. Use identifier code "0005" in column 1 to report this information. Report the number of other-than-clean claims processed in 46 days or longer on Form Y of the CROWD system, under column 1 on a line using code "0006" as the identifier.

The following types of claims do not apply to this instruction:

- Claims where the Social Security Administration blocks a beneficiary's Health Insurance Claim Number (HIC),

- Claims the contractors are required to hold due to CMS instructions,

- Translator rejects,
- Claims where CWF is unable to process due to technical issues with the CWF beneficiary record or beneficiary identification issues,
- Claims submitted by a hospice, and
- Claims in development due to processing requirements (e.g. medical review), in Publication 100-8, the Medicare Program Integrity Manual.

80.4 - Enforcement of Provider Billing Timelines and Accuracy Standard to Continue PIP (Periodic Interim Payment)

(Rev. 1, 10-01-03)

A3-3676

A. General

To remain on PIP, providers, (with the exception of HHAs that do not receive PIP with the advent of PPS mandated by law on October 1, 2000), must submit 85 percent of their bills timely and accurately. Timely and accurately means that 85 percent of its bills (excluding those listed below) are submitted within 30 days of discharge and pass front-end edits for consistency and completeness. A bill is not considered received unless it can pass FI edits. FIs must accumulate statistics on inpatient and SNF billing performance for each PIP provider to monitor whether it meets this requirement. These instructions do not effect bi-weekly payments for pass-throughs (Medicare Provider Reimbursement Manual, (PRM) §2405.2) and for adjustments to indirect cost for medical education (PRM §2405.3).

The evaluation for timeliness of billing should be consistent with the frequency for monitoring the payment amounts under the PIP program. Thus, for non-PPS hospitals and SNFs the evaluation process is scheduled at 3-month intervals and PPS providers are evaluated every 4 months. The evaluation includes data from the entire 3- or 4-month period. In determining whether a provider submitted its bills within 30 days of discharge or through date on interim bills, count the date from Form CMS-1450 FL6 (through date) to the date received by the FI. If the provider does not meet the criteria, discontinue PIP immediately. The periodic performance report that is provided in accordance with subsection B will constitute advance notice before discontinuing PIP.

Exclude the following:

- MSP cases (value codes 12-16);
- Any special situation identified by the provider or FI that is documented as beyond provider control. Exclusions must be approved by the RO; and
- Bills that have not passed FI front-end edits for acceptance. (Such bills are counted only when acceptable to the shared system edit processes.)

The FIs must accumulate statistics monthly and summarize them for the entire evaluation period.

B. Procedure for Measuring and Reporting to Hospitals and SNFs

The FIs accumulate a record for each bill that passes front-end edits. Bills must be counted in the month received regardless of the discharge month. No later than 10 work-days after the end of the month, FIs furnish a report to each hospital/SNF. For the month indicating the following:

- The total number of bills received;
- The number not excluded as described in section A;
- The number not excluded received in 30 days or less;
- The percentage not excluded received in 30 days or less.

Also, for providers that fail to meet the standard, furnish individual case identification of claims that were not billed within 30 days of discharge. List only claims that are not excluded and are identified in subsection A. The report must be furnished in electronic media, unless the FI determines a paper listing would be cheaper to process. If electronic media is used, use the following record format. Determine the physical characteristics of the file.

Fld	Description	Psn.	Picture	Just	From	Thru
1	Provider Number	6	X(6)	L	001	006
2	Blank	3	X(3)		007	009
3	Blank	1	X		010	
4	HIC Number	12	X(12)	L	011	022
5	Blank	1	X		023	
6	Beneficiary Surname	6	X(6)	L	024	029
7	Blank	1	X		030	
8	Patient Control Number	17	X(17)	L	031	047
9	Blank	1	X		048	
10	From Date	6	9(6)		049	054
11	Blank	1	X		055	
12	Discharge or Thru Date	6	9(6)		056	061
13	Blank	1	X		062	
14	Date Bill Received	6	9(6)		063	068
15	Blank	1	X		069	
16	Days Elapsed	4	9(4)	R	070	073

If sub-provider identification is used, positions 7, 8, and 9 may be utilized.

C. Reinstatement of PIP

Do not reinstate PIP for a provider until it meets all criteria in PRM §§2405.1.B and 2407 and has met the requirements in subsection A for timeliness and accuracy for six consecutive months.

D. New Request for PIP

Evaluate new requests for PIP as in subsections A and B. At least three months experience is required for new requests, (except for new providers with less experience).

E. Hospitals on 100 Percent PRO Prepayment Review

The 30-day requirements for submitting bills to FIs are not applicable. The RO makes determinations of timely and accurate bill submission by hospitals for which the PRO reviews 100 percent of the discharges before payment. However, other standards remain applicable for retaining PIP in such cases. See PRM §§2405.1.B and 2407 for the requirements.

80.5 - Do Not Forward Initiative (DNF)

(Rev. 1, 10-01-03)

80.5.1 - Carrier DNF Requirements

(Rev. 1, 10-01-03)

B3-4021, B-02-023

This initiative entails the use of "Return Service Requested" envelopes to preclude the forwarding of Medicare checks to locations other than those recorded on the Medicare provider files. The use of these envelopes permit the U.S. Postal Service to return Medicare checks to local carriers and durable medical equipment regional carriers (DMERCs) free of charge, as the postal service has done for the DMERCs since February 1997.

A. Returned Check Process for Carriers and DMERCs

The CMS requires carriers and DMERCs to use "Return Service Requested" envelopes for all checks they mail to providers and suppliers. In addition, carriers and DMERCs must use "return service requested" envelopes for hardcopy remittance advices, with respect to providers that have elected to receive hardcopy remittance advices. They do not use "return service requested" envelopes for beneficiary correspondence, such as Explanations of Benefits (EOB) or Medicare Summary Notices (MSNs), or for overpayment demand letters.

Carriers and DMERCs must be in compliance with postal regulations when developing their DNF envelopes. Carriers and DMERCs must sort outgoing mail to identify provider or supplier checks, and must only place these checks in "Return Service Requested" envelopes. The postal service will forward remittance advice without checks and checks to beneficiaries.

When the check is returned, if applicable, the postal service will provide the carrier or DMERC with a new address or reason for nondelivery. If the postal service supplies a carrier or DMERC with a new address for the provider or supplier with the returned check or remittance, do not automatically change the address of the provider or supplier or re-mail the check/remittance. (See the change of address process described below.)

Once the post office returns an envelope, record the check number and any correspondence in the envelope, using normal procedures for incoming mail. For example, microfiche, and photocopy the mail. Contractors must also log and account for the checks, noting pertinent information,

such as the provider or supplier's name and number, date of the check, the check number, the amount of the check, and the date the check was returned.

The carrier's or DMERC's financial staff must either reissue the check based upon receipt of an updated, verified address, or systematically cancel the returned check and notify the provider enrollment staff that a provider must be flagged DNF. The provider enrollment staff must annotate the provider or supplier's file with a DNF flag, pending receipt of a verified address. Carriers and DMERCs must process any subsequent claims a flagged provider or supplier submits through the Common Working File (CWF) to completion, but must not generate any additional check or checks for that provider or supplier until an authorized address correction is received and the flag removed.

In addition, provider enrollment staff must alert the benefit integrity staff in the event that any investigations are currently taking place, which are affiliated with flagged providers or suppliers. DMERCs must notify the National Supplier Clearing House (NSC). All carriers must implement a standardized reporting format for this process.

NOTE: Because some providers get paid through electronic funds transfer (EFT), there may be cases where a provider does not have a correct address on file, but the contractor continues to pay the provider through EFT. This instruction applies to providers receiving paper.

B. Change of Address Process for Local Carriers and DMERCs

When a flagged provider or supplier notifies you that they have not received their checks, direct them to your provider enrollment staff. The provider or supplier must complete a change of address Form CMS-855C, or other written notification. The form or written notification must bear an original signature from an authorized representative of the entity that completed the original registration form. No copies, faxes, or stamps are acceptable. For purposes of this process, the most important address is the "Pay To" address. If the provider or supplier did not furnish the "Pay To" address on Form CMS-855C, or other written notification, return it to the provider or supplier. The provider or supplier must furnish the "Pay To" address. Addresses may not be changed based on telephone calls.

Although the Pay to Address is the most critical, CMS requires corrections to all addresses before the contractor can remove the DNF flag and begin paying the provider or supplier again. Therefore, carriers may not release any payments to DNF providers until the provider enrollment area or the NSC has verified and updated all addresses for that provider's location

When a provider enrollment staff member verifies an address, the provider must update the address for the provider or supplier and remove the DNF flag.

Provider enrollment staff must send a daily report to financial staff, advising which providers and suppliers are no longer flagged DNF. Financial staff must generate all payment that is due the provider or supplier for claims that were adjudicated for the time period the provider or supplier was flagged.

C. Educational Requirements

1. Contractors must publish the requirement that providers must notify the Part B carrier or NSC of any changes of address, both on their Web sites and in their next regularly scheduled bulletins.

2. Contractors must continue to remind suppliers and providers of this requirement in their bulletins at least yearly thereafter.

80.5.1.1 - Reporting Requirements - Carriers

(Rev. 989, Issued: 06-23-06, Effective: 10-01-06, Implementation: 10-02-06)

A. Field Definitions for DNF Spreadsheet

To be certain that all parties understand what information CMS needs to get from these reports, the following definitions have been created for each field. No rolling or annual totals should be included.

Suppliers/Providers Flagged/Corrected Counts

Field #	Definition
1	**New Flags:** the number of all suppliers or providers the contractor flagged for DNF during the reporting quarter (regardless of whether or not they still have a flag, and regardless of whether the contractor flagged them due to a returned check or returned remittance advice), that were not flagged at the end of the previous reporting quarter.
2	**Removed Flags:** the number of all suppliers or providers who supplied a verified, correct address, causing the contractor to remove the DNF flag, during the reporting quarter.
3	**Total Flags:** the total number of all suppliers or providers who still have a DNF flag on the last day of the reporting quarter, regardless of whether the contractor flagged them due to a returned check or returned remittance advice), including those the contractor flagged in a previous quarter who did not supply a verified, corrected address.

Check Counts

Field #	Definition
4	**Returned Checks:** the total number of checks the post office returned to the contractor due to an incorrect address during the reporting quarter, regardless of whether or not the supplier provided a corrected address and may have been reissued the check during the quarter.
5	**Held Checks:** the total number of all checks that contractors did not issue due to DNF flags in the system during the reporting quarter, regardless of whether or not the supplier provided a corrected address and was later paid.
6	**Reissued and Released Checks:** the total number of all checks (both those the post office returned, and those the contractor had been holding due to a DNF flag in the system) the contractors reissued or released during the reporting quarter, to suppliers or providers who submitted a verified, correct address.

Dollar Counts

Field #	Definition
7	**Amount Returned:** the total dollar amount of all checks the post office returned due to an incorrect address during the reporting quarter, that you are still holding at the end of the reporting quarter.
8	**Amount Held:** the total dollar amount of all checks the contractors did not issue due to DNF flags in the system during the reporting quarter, that you are still holding at the end of the reporting quarter.
9	**Amount Reissued/Released:** the total dollar amount of all payments (both those the post office returned, and those the contractor had been holding due to a DNF flag in the system) the contractors reissued during the reporting quarter, to suppliers or providers who submitted a verified, correct address.
10	**Net Amount:** the value in field 7 plus the value in field 8, minus the value in field 9 - it is possible that this number will be a negative figure.

NOTE A

If a contractor flags a provider or supplier for DNF more than one time within a quarter, only count that supplier or provider once for fields 1, 2, and 3.

NOTE B

Multi-Carrier Systems contractors may use a claim count for items 4-6, 8, and 9, rather than a check count.

B. Systems Requirements

Carriers and DMERCs generate reports out of the shared systems and must be able to generate figures for each field in accordance with the above descriptions.

Furthermore, shared systems must be certain that when the system calculates the totals, it includes the first returned check that prompted the DNF flag. The shared systems should program the reports so that the contractors may request monthly detail reports to verify the quarterly totals. However, carriers only send the quarterly reports to CMS central office (CO) and regional office (RO), not the monthly reports.

C. Quarterly Reporting Requirements

Contractors must forward the DNF reports to their appropriate RO and CO contacts, by the fifteenth day of each month that follows the end of a quarter (i.e., January 15, April 15, July 15, and October 15). DMERCs must e-mail their reports to renee.hildt@cms.hhs.gov, and carriers e-mail their reports to melvia.pagelasowski@cms.hhs.gov.

D. Other Requirements

Contractors must continue to follow all other aspects of the DNF reporting initiative (e.g., use of "Return Service Requested" envelopes, assignment of a DNF flag to appropriate providers/suppliers) as instructed in the §80.5.

E. Examples - Blank Report

DO NOT FORWARD PROJECT			
Activity for the _____ Quarter of FY _____	**$$**	**Region**	**Medicare Contractor**
Suppliers/Providers Flagged/Correct Counts			
1. # new supplier/providers flagged during the reporting quarter			
2. # suppliers/providers whose flags were removed, end of the reporting quarter			
3. **#** suppliers/providers flagged, end of the reporting quarter			
Check Counts			
4. **#** new checks returned during the reporting quarter			
5. **#** of checks held during the reporting quarter			
6. **#** checks reissued during the reporting quarter			
Dollar Counts			
7. **$** amount of new checks returned during the reporting quarter			

DO NOT FORWARD PROJECT			
Activity for the _____ Quarter of FY _____	**$$**	**Region**	**Medicare Contractor**
8. **$** amount of checks held during the reporting quarter			
9. **$** amount reissued during the reporting quarter			
10. **$** amount returned to trust fund during the reporting quarter			
Report By:_____			
Report Date:_____			

Sample Completed Report

SAMPLE - DO NOT FORWARD PROJECT			
Activity for the 3RD Quarter of FY 2003	**$$**	**Region**	**Medicare Contractor**
		Q	**XYZ Contractor**
Suppliers/Providers Flagged/Correct Counts			
1. # new supplier/providers flagged during the reporting quarter	125		
2. # suppliers/providers whose flags were removed, end of the reporting quarter	30		
3. **#** suppliers/providers flagged, end of the reporting quarter	117		
Check Counts			
4. **#** new checks returned during the reporting quarter	40		
5. **#** of checks held during the reporting quarter	100		
6. **#** checks reissued during the reporting quarter	60		

SAMPLE - DO NOT FORWARD PROJECT			
Activity for the 3RD Quarter of FY 2003	**$$**	**Region**	**Medicare Contractor**
		Q	**XYZ Contractor**
Dollar Counts			
7. **$** amount of new checks returned during the reporting quarter	100,000		
8. **$** amount of checks held during the reporting quarter	600,000		
9. **$** amount reissued during the reporting quarter	500,000		
10. **$** amount returned to trust fund during the reporting quarter	200,000		
Report By: Jane Doe			
Report Date: April 02, 2003			

80.6 – Processing All Diagnosis Codes Reported on Claims Submitted to Carriers

(Rev.735, Issued: 10-31-05, Effective: 04-01-06, Implementation: 04-03-06)

Carrier standard systems shall capture and process all diagnosis codes reported on a claim (both paper and electronic) up to the maximum permitted under the format. The CWF shall process and maintain all diagnosis codes reported to CWF on a carrier processed claim.

90 - Patient Is a Member of a Medicare Advantage (MA) Organization for Only a Portion of the Billing Period

(Rev. 493, Issued: 03-04-05, Effective: 04-04-05, Implementation: 04-04-05)

Where a patient either enrolls or disenrolls in an MA organization (See Pub. 100-01, the General Information, Eligibility, and Entitlement Manual, Chapter 5, §80 for definition) during a period of services, two factors determine whether the MA organization is liable for the payment.

- Whether the provider is included in inpatient hospital or home health PPS, and
- The date of enrollment.

Hospital Services

If the provider is an inpatient acute care hospital, inpatient rehabilitation facility or a long term care hospital, and the patient changes MA status during an inpatient stay for an inpatient institution, the patient's status at admission or start of care determines liability.

If the hospital inpatient was not an MA enrollee upon admission but enrolls before discharge, the MA organization is <u>not</u> responsible for payment.

For hospitals exempt from PPS (children's hospitals, cancer hospitals, and psychiatric hospitals/units) and Maryland waiver hospitals, if the MA organization has processing jurisdiction for the MA involved portion of the bill, it will direct the provider to split the bill and send the appropriate portions to the appropriate FI or MA organization. When forwarding a bill to an MA organization, the provider must also submit the necessary supporting documents.

If the provider is not a PPS provider, the MA organization is responsible for payment for services on and after the day of enrollment up through the day that disenrollment is effective.

Home Health

If the patient was enrolled in the MA organization before start of care, the MA organization is liable until disenrollment. Upon disenrollment, an episode must be opened under home heath PPS for billing to the FI.

If the beneficiary was not an MA enrollee upon admission but enrolls before discharge, the home health PPS episode will end as of the day before the MA enrollment. The episode will be proportionately paid according to its shortened length (i.e., paid a partial

episode payment [PEP] adjustment). The MA organization is responsible for payment as of the MA enrollment date.

91 - Moral and Religious Fee for Service Claims for Medicare Beneficiaries Enrolled in Certain Medicare Advantage (MA) Plans

100 - Medicare as a Secondary Payer
(Rev. 1, 10-01-03)

HO-301, HO-469, CFR 411.32

The provider is required to determine whether Medicare is a primary or secondary payer for each inpatient admission of a Medicare beneficiary and outpatient encounter with a Medicare beneficiary. Refer to the Medicare Secondary Payer Manual for specific MSP rules and for special admission and claims processing procedures for providers, suppliers, FIs, and carriers.

Medicare benefits are secondary to benefits payable by a third party payer, even if State law or the third party payer states that its benefits are secondary to Medicare benefits or otherwise limits its payments to Medicare beneficiaries. Medicare will make secondary payments except when the provider or supplier is either obligated to accept, or voluntarily accepts, as full payment, a third party payment that is less than its charges. When a provider or supplier, or a beneficiary who is not physically or mentally incapacitated, receives a reduced third party payment because of failure to file a proper claim, the Medicare secondary payment may not exceed the amount that would have been payable if the third party payer had paid on the basis of a proper claim.

The law mandates that Medicare is secondary payer for:

- Claims involving Medicare beneficiaries age 65 or older who have GHP coverage based upon their own current employment status with an employer that has 20 or more employees, or that of their spouse of any age, or based upon coverage by a multiple employer, or multi-employer group health plan by virtue of their own, or a spouse's, current employment status and the GHP covers at least one employer with 20 or more employees. An individual has current employment status if the individual is actively working as an employee, is the employer (including a self-employed person), or is associated with the employer in a business relationship; or is not actively working, but meets all of the following conditions:
    - o Retains employment rights in the industry;
    - o Has not had employment terminated by the employer,
    - o Is not receiving disability payments from an employer for more than six months;
    - o Is not receiving social security disability benefits; and
    - o Has group health plan (GHP) coverage based on employment that is not COBRA continuation coverage.

Examples of individuals who fall in the second group are teachers, employees who are on furlough or sick leave, and active union members between jobs.

- Claims involving beneficiaries eligible for or entitled to Medicare on the basis of end stage renal disease (ESRD) during a period of 30 months) except where an aged or disabled beneficiary had GHP or LGHP coverage which was secondary to Medicare at the time ESRD occurred;

NOTE: The Balanced Budget Act of 1997 extended the ESRD coordination period to 30 months from 18 months for any individual whose coordination period began on or after March 1, 1996. Individuals whose period began before that date have an 18-month coordination period. This issue may need to be clarified with ESRD beneficiaries upon admission.

- Claims involving automobile or non-automobile liability or no-fault insurance;
- Claims involving government programs, e.g., Worker's Compensation (WC), services authorized and paid for by the Department of Veterans Affairs (DVA), or Black Lung (BL) benefits; and
- Claims involving Medicare beneficiaries under age 65 who are entitled to Medicare on the basis of disability and are covered by an LGHP (plans or employers, or employee organizations, with at least one participating employer that employs 100 or more employees) based upon the beneficiary's own current employment status or the current employment status of a family member.

110 - Provider Retention of Health Insurance Records

(Rev. 1, 10-01-03)

HO-413, HH-480, SNF-545

The provider must maintain health insurance materials related to services rendered under title XVIII for the retention periods outlined below unless State law stipulates a longer period. It must keep them available for reference by CMS, carrier, or FI, DHHS audit, or specially designated components for bill review, audit, and other references.

110.1 - Categories of Health Insurance Records to Be Retained

(Rev. 1, 10-01-03)

HO-413, HH-480, SNF-545.1

Providers retain records in all categories as applicable:

A. Billing Material

Provider copies of Form CMS-1450 and any other supporting documents, e.g., charge slips, daily patient census records, and other business and accounting records referring to specific claims.

B. Cost Report Material

All data necessary to support the accuracy of the entries on the annual cost reports, including original invoices, cancelled checks, and provider copies of material used in preparing them. Also include other similar cost reports, schedules, and related

worksheets and contracts or records of dealings with outside sources of medical supplies and services or with related organizations.

C. Medical Record Material

For hospitals, utilization review committee reports and discharge summaries. For hospitals and home health agencies, physicians' certifications, and recertifications, and clinical and other medical records relating to health insurance claims.

D. Provider Physician Materials

Provider physician agreements upon which Part A and Part B allocations are based.

After payment of the bill, the provider should not retain administrative and billing work records if the material does not represent critical detail in support of summaries related to these records. These include punch cards, adding machine tapes, or other similar material not required for record retention.

110.2 - Microfilming Records

(Rev. 1, 10-01-03)

SNF-545.3, HO-413, HH-480

The provider may microfilm all health insurance records.

Billing material and related attachments that the provider furnished to the carrier or FI may be microfilmed providing the microfilm accurately reproduces all original documents.

The provider must retain copies of all other categories of health insurance records in their original form. If it microfilms them, it should store them in a low cost facility for the retention period described in §110.3.

110.3 - Retention Period

(Rev. 1, 10-01-03)

The hospital must maintain a medical record for each inpatient and outpatient. Medical records must be accurately written, promptly completed, properly filed and retained, and accessible. The provider must use a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries.

The provider (hospital, skilled nursing facility, and home health agency) must retain medical records in their original or legally reproduced form for a period of at least five years after it files with its FI the cost report to which the records apply, unless State law stipulates a longer period of time.

After payment of the bill, the provider need not retain administrative and billing work records provided that, and only to the extent that, such material does not represent critical detail in support of summaries related to the records outlined in §110.2. These records include punch cards, adding machine tapes, internal controls, or other similar material not required for record retention.

Providers must retain clinical records as follows:

- The period of time required by State law;
- Five years from the date of discharge when there is no requirement in State law; or
- For a minor, three years after a resident reaches legal age under State law.

110.4 - Destruction of Records

(Rev. 1, 10-01-03)

HO-413.1, HH-480.1, SNF-545.4

The provider may destroy material that no longer needs to be retained for title XVIII purposes, unless State law stipulates a longer period of retention.

To insure the confidentiality of the records, they must be destroyed by shredding, mutilation or other protective measures. The method of final disposition of the records may provide for their sale as salvage. The provider must report monies received as an adjustment to expense in the cost report for the year sold.

120 - Detection of Duplicate Claims

(Rev. 492, Issued: 03-04-05, Effective: 07-01-05, Implementation: 07-05-05)

Hard Coding of Duplicate

Only exact duplicate edits lend themselves to "hard coding" to prevent a Medicare contractor from overriding a shared system edit. Edits mentioned below may not be user-controlled.

A. Carriers

Exact duplicates for carriers are as follows:

- HIC Number;
- Provider Number;
- From Date of Service;
- Through Date of Service;
- Type of Service;
- Procedure Code;
- Place of Service; and
- Billed Amount.

B. FIs

Exact duplicates for FIs are as follows:

- HIC number;
- Type of Bill;
- Provider Identification Number;

- From Date of Service;
- Through Date of Service;
- Total Charges (on the line or on the bill); and
- HCPCS, CPT-4, or Procedure Code modifiers.

C. Additional FI Instructions

Whenever any of the following claim situations occur, the FI develops procedures to prevent duplicate payment of claims. This includes:

- Outpatient payment is claimed where the date of service is totally within inpatient dates of service at the same or another provider. Do not consider outpatient services provided on the day of discharge within the inpatient dates of service.
- Outpatient bill is submitted for services on the day of an inpatient admission or the day before the day of admission to the same hospital.
- Outpatient bill overlaps an inpatient admission period.
- Outpatient bill for services matches another outpatient bill with a service date for the same revenue code at the same provider or under a different provider number.

Outpatient services means services for which you prepare an outpatient HUOP record from all providers.

1. History File - Paid Claims

The FIs must maintain a history file containing information about each claim processed. The file may consist of the claim or information from it. It must contain the following minimum information:

- Beneficiary HICN;
- Beneficiary name information;
- Provider identification (name or number); and
- Billing period from the claim.

Claims or claims information in the history file may be transferred to inactive files. However, the FI must have the facility to recall such claims or information if a claim for the beneficiary involving the same time period is received.

2. History File - Pending Claims

Contractors must have controls to prevent a duplicate claim being paid while two claims are in the process within the system at the same time. This may be accomplished through a special check of in-process claims or in the history file for paid claims. The file should contain the same minimum information indicated in subsection A above. The check should be performed prior to sending the claim to CWF.

3. Criteria for Detecting Potential Duplicates

A “potential duplicate” claim is a claim being processed which, when compared to the history or pending file, has the following characteristics:

- Match on the beneficiary information;
- Match on provider identification, and
- One day or more overlap in billing period indicated.

The FIs examine and compare to the prior bill any bill that is identified as a potential duplicate. If the services (revenue or HCPCS codes) on a claim duplicate the services for the other, FIs should check the diagnosis. If the diagnosis codes are duplicates, obtain an explanation from the provider before making payment.

Required action:

Review the FI records to determine if payment has been made or a suspected duplicate claim is in process;

- Determine what data are needed to support payment or a cancel action on the claim;
- In cases where payment has been made, initiate appropriate recovery action; and
- Instruct the provider to refund to the beneficiary any Part B deductible and/or coinsurance collected, or use the indemnification process, as appropriate.

Effective for claims received on or after July 1, 2005, Medicare FIs must add an informational indicator to the Common Working File (CWF) transaction record when, as a result of an FI audit/edit or CWF reject, the FI examines what appears to be a duplicate item or service and approves it for payment. Use the following indicator:

Value 1: suspected duplicate review performed – service determined not to be a duplicate and is approved for payment

The FIs will place the appropriate value in the new indicator field of the HUIP/HUOP/HUHH/HUHC record. CWF shall pass the indicator to NCH.

The FIs shall not change their current editing procedures for duplicate claims.

4. Analysis of Patterns of Duplicate Claims

The FI shall establish a system for continuing analysis of duplicate claims. This includes the systematic evaluation of returned "Medicare Summary Notices" from beneficiaries and communications from providers indicating a duplicate payment has been made, as well as returned checks from any payee.

The FI system should provide for analyzing duplicate claim receipts to determine whether certain providers are responsible for duplicates and if so identify those providers. The FI should educate such providers to reduce the number of duplicates they submit. Should those providers continue to submit duplicate claims, the FI should initiate program integrity action.

D. Suspect Duplicates Reviewed by Carriers/DMERCs for Duplication and Appropriately Paid

Carriers and DMERCs

Effective for claims received on or after July 1, 2005, Medicare Carriers and Durable Medical Equipment Regional Carriers (DMERCs)) must add an informational indicator to the Common Working File (CWF) transaction record when, as a result of a carrier audit/edit or CWF reject, the carrier examines what appears to be a duplicate item or service and approves it for payment. Use the following indicator:

Value 1: suspected duplicate review performed – service determined not to be a duplicate and is approved for payment

Carriers and DMERCs will place the appropriate value in the new indicator field of the HUBC/HUDC record. CWF shall pass the indicator to NCH.

Carriers and DMERCs shall not change their current editing procedures for duplicate claims.

130 - Adjustments and Late Charges

(Rev. 1, 10-01-03)

A3-3664, HO-411.1, HO-IM411.1, HH-445, A3-3610.8, HO-415.11

130.1 - General Rules for Submitting Adjustment Requests

(Rev. 1, 10-01-03)

A3-3664.B

Adjustment requests are the most common mechanism for changing a previously accepted bill. They are required to reflect the results of QIO medical review. CMS may also require adjustments if it discovers that bills have been accepted and posted in error to a particular record. Adjustments that only recoup or cancel a prior payment are "credits" and must match the original in the following fields:

- Intermediary control number (ICN/DCN);
- Surname;
- HICN

When a definite match cannot be made on the three fields above, the provider's FI will use the fields below as needed. Note that for older claims, ICN/DCN probably will not match.

- Date of birth;
- Admission Date for inpatient, (Date of First Service for outpatient) unless changed by this adjustment requests; and
- From/thru dates for inpatient, (Date of First Service/Date of Last Service for Outpatient), unless changed by this adjustment request.

Cancel-only adjustment requests are not acceptable, except in cases of incorrect provider identification numbers and incorrect HICNs. The provider must submit a corrected replacement bill (bill type xx1) to its FI after submitting the cancel-only request for the incorrect bill.

The provider must submit all other adjustment requests as debits only. It shows the ICN/DCN of the bill to be adjusted as described above, with the bill type shown as xx7. It submits adjustment requests to its FI either electronically or on hard copy. Electronic submission is preferred.

The FI must enter the following bill types that relate to the entity generating the adjustment request:

xx7	Provider (debit)
xx8	Provider (cancel)
xxF	Beneficiary
xxG	CWF
xxH	CMS
xxI	FI
xxM	MSP
xxP	QIO
xxJ	Other
xxK	OIG/GAO

The provider submits all adjustment requests as bill type xx7 or xx8. Since several different sources can initiate an MSP adjustment (e.g., the provider, CWF, or the FI), the MSP designation, xxM, takes priority over any other source of an adjustment except OIG/GAO. When the provider submits an MSP adjustment request to the FI, the FI will change the bill type to xxM. These priorities refer only to the designation of the source of the adjustment. The difference between CWF generating the adjustment request and CMS generating the adjustment request is:

An adjustment request is CWF-generated if the FI receives a CWF alert or a CMS-L1002.

The FI prepares an adjustment if instructed by CMS CO or CMS RO to make a change. Typically, the FI receives such direction from CMS when it decides to retroactively change payment for a class or other group of bills. Occasionally, CMS will discover an error in the processing of a single bill and direct the FI to correct it.

If the FI furnished the Part B carrier a copy of the original bill that is being adjusted, it must furnish the carrier a copy of the adjusted bill.

If adjustments are rejected by CWF for additional corrections, they must be corrected and resubmitted. Even if a letter from CMS requests the adjustment action, the FI must

submit the adjustment request in its CWF record. If a rejected adjustment request is determined to be unnecessary, the FI stops the adjustment action upon receipt of correction.

Where an adjustment request changes subsequent utilization, the FI notes this and processes adjustments to subsequent bills if it services the provider.

If the FI does not service the provider, CMS will contact the FIs that submitted bills with subsequent billing dates that are affected by the adjustments via a CMS-L389 or CMS-L1001 upon receipt of the adjusted bills in CWF. (An indicator is set by CMS on its records upon advising a FI of the appropriate adjustment actions.)

130.1.1 - Adjustment Bills Involving Time Limitation for Filing Claims

(Rev. 1, 10-01-03)

A3-3664.D

If a provider fails to include a particular item or service on its initial bill, an adjustment request(s) to include such an item(s) or service(s) is not permitted after the expiration of the time limitation for filing a claim. However, to the extent that an adjustment request 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.

130.1.2 - Claim Change Reasons

(Rev. 1, 10-01-03)
HO-411.2, HO-IM411.2, HH-445

130.1.2.1 - Claim Change Reason Codes

(Rev. 1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

The provider submits one of the following claim change reason codes to its FI with each debit-only or cancel-only adjustment request:

Bill Type	Reason Code	Explanation
Xx7	D0 (zero)	Change to service dates
Xx7	D1	Change in charges
Xx7	D2	Change in revenue codes/HCPCS - HIPPS
Xx7	D3	Second or subsequent interim PPS bill - PPS inpatient hospital only
Xx7	D4	Change in GROUPER input (diagnoses or procedures) - PPS inpatient hospital).

Bill Type	Reason Code	Explanation
Xx8	D5	Cancel-only to correct a HICN or provider identification number
Xx8	D6	Cancel-only to repay a duplicate payment or OIG overpayment (includes cancellation of an outpatient bill containing services required to be included on the inpatient bill.)
Xx7	D7	Change to make Medicare the secondary payer
Xx7	D8	Change to make Medicare the primary payer
Xx7	D9	Any other change
Xx7	E0 (zero)	Change in patient status

The provider may not submit more than one claim change reason code per adjustment request. It must choose the single reason that best describes the adjustment it is requesting. It should use claim change reason code D1 only when the charges are the only change on the claim. Other claim change reasons frequently change charges, but the provider may not "add" reason code D1 when this occurs.

The claim change reason code is entered as a condition code on the hard copy Form CMS-1450 or the electronic equivalent. For reason codes D0-D4 and D7-D9, the biller submits a debit-only adjustment request, bill type xx7. For reason codes D5 and D6, it submits a cancel-only adjustment request, bill type xx8.

130.1.2.2 - Edits on Claim Change Reason Codes

(Rev. 1, 10-01-03)

The following edits are based on the claim change reason code. The FI must apply them to each incoming adjustment request.

- If the type of bill is equal to xx7 and the claim change reason code is not equal to D0-D4, D7-D9, or E0, the FI rejects the request back to the provider with the following error message, "Claim change reason code must be present and equal to D0-D4, D7-D9, or E0 for a debit-only adjustment request."
- If the type of bill is equal to xx8 and the claim change reason code is not equal to D5-D6, the FI rejects the request back to the provider with the following error message, "Claim change reason code must be present and equal to D5-D6 for a cancel-only adjustment request."
- If the type of bill is equal to xx7 or xx8 and the ICN/DCN of the claim being adjusted is not present, the FI rejects the request back to the provider with the following message, "ICN/DCN of the claim being adjusted is required for an adjustment request."

- If more than one claim change reason code is present on the provider's request, the FI rejects the request back to the provider with the following message; "only one claim change reason code may apply to a single adjustment request from a provider. The FI chooses the single claim change reason code that best describes the reason for the provider's request and resubmit."
- If the provider submits an adjustment request as type of bill not equal to xx7 or xx8, the FI rejects the request back to the provider with the message, "Provider submitted adjustment request must use type of bill equal to xx7 or xx8."
- If the claim change reason code is equal to D0, the FI compares the beginning and ending dates on the provider's request to those on the claim to be adjusted on its history. If these dates are the same, it rejects the request back to the provider with the message, "Dates of service must change for claim change reason code D0."
- If the claim change reason code is equal to D1, the FI compares the total and line item charges on the provider's request to those on the claim to be adjusted on its history. If these changes are the same, the FI rejects the request back to the provider with the message, "Charges must be changed for claim change reason code D1."
- If the claim change reason code is equal to D2 (revenue code/HCPCS or HIPPS), the FI compares revenue codes/HCPCS or HIPPS on the provider's request to those on the claim to be adjusted on its history. If these codes are the same, it rejects the request back to the provider with the message, "Revenue codes/HCPCS or HIPPS must change for claim change reason code D2."
- If the claim change reason code is equal to D3 (PPS inpatient hospital only), the FI compares the ending date on the hospital's request to that on the claim to be adjusted on its history. If these dates are the same, it rejects the request back to the hospital with the message, "Thru dates must change for the claim change reason code D3."
- If the claim change reason code is equal to D4 (PPS inpatient hospital), the FI compares diagnosis and procedure codes on the provider's request to those on the claim to be adjusted on its history. If these codes are the same and are in the same sequence, it rejects the request back to the provider with the message, "Diagnoses and/or procedures must change for claim change reason code D4."
- If the claim change reason code is equal to D5 or D6, type of bill must be equal to xx8 on the provider's request. If type of bill is not equal to xx8, the FI rejects the request back to the provider with the message, "Type of bill must be equal to xx8 for claim change reason codes D5 or D6."
- If the claim change reason code is equal to D7, an MSP value code (12-16, 41-43, or 47) must be present, if a value code, 12-16, 41-43, or 47, is not present, the FI rejects the request back to the provider with the message, "An MSP value code (12-16, 41-43, or 47) must be present for claim change reason code D7."
- If the claim change reason code is equal to D7, and one or more of value codes 12-16, 41-43, and/or 47 is present but each value amount is equal to 0 (zero) or

spaces, the FI rejects the request back to the provider with the message, “invalid value amount for claim change reason code D7.”

- If the claim change reason code is equal to D8, and a value code 12-16, 41-43, or 47 is present, the FI rejects the claim back to the provider with the message, “Invalid value code for claim change reason D8.”
- If the claim change reason code is equal to E0, the FI compares patient status on the provider’s request to that on the claim to be adjusted. If patient status is the same, the FI rejects the request back to the provider with the message, “Patient status must change for claim change reason E0.”

The FI must suspend for investigation all adjustment requests with claim change reason codes D8, and D9. Providers that consistently use D9 will be investigated and, if a pattern of abuse is evident, may be reported to the OIG.

130.1.2.3 - Additional Edits

(Rev. 1, 10-01-03)

The FI must perform the following additional edits and investigate adjustment requests the provider submits:

- A full denial once the bill is paid, except to accomplish retraction of a duplicate payment;
- Inpatient Hospital Only - A change in DRG based on a change in age or sex;
- A change in deductible;
- An adjustment request that changes a previously submitted QIO adjustment request;
- An adjustment of a bill due to a change in utilization or spell data on another bill;
- A reopening to change a no-payment bill to a payment bill;
- A reopening to pay a previously denied line item;
- An adjustment request the provider initiates with a claim change reason code equal to D7, with the Medicare payment amount equal to or greater that the previously paid amount; or
- An adjustment request with a claim change reason code equal to E0, and the claim is for an inpatient PPS hospital. The FI must investigate if the change is from patient status 02, transferred to another acute care facility.

130.1.3 - Late Charges

(Rev. 493, Issued: 03-04-05, Effective: 04-04-05, Implementation: 04-04-05)

The provider submits late charges on bills to the FI as bill type xx5. These bills contain only additional charges. However, if the late charge is for:

- Services on the same day as outpatient surgery subject to the ASC limit;

Services on the same day as services subject to OPPS;

- ESRD services paid under the composite rate;
- Inpatient accommodation charges;
- Services paid under HH PPS; and
- Inpatient hospital or SNF PPS ancillaries.

It must be submitted as an adjustment request.

The provider may submit the following charges omitted from the original paid bill to the FI as late charges:

- Any outpatient services other than the exceptions stated in this paragraph. This includes late charges for non-HH PPS services under Part B, hospice services other than the services of hospice-employed attending physicians, hospital outpatient services except those on the day of ambulatory surgery subject to the ASC payment limitation or the day of outpatient services subject to OPPS, RHC services, OPT services, SNF outpatient services, CORF services, FQHC services, CMHC services, ESRD services not included in the composite rate; and
- Any inpatient SNF ancillaries or inpatient hospital ancillaries other than from PPS providers. The provider may not submit late charges (xx5) for inpatient hospital or SNF accommodations. The provider must submit these as adjustments (bill type xx7).

The FI has the capability to accept xx5 bill types electronically and process them as initial bills except as described in the following paragraph.

The FI also performs the following edit routines on any xx5 type bills received:

- Pass all initial bill edits, including duplicate checks.
- Must not be for any of: Inpatient hospital or SNF PPS ancillaries, inpatient accommodations in any facility, services on the same day as outpatient surgery subject to the ASC payment limitation, services on the same day as services subject to OPPS, or ESRD services included in the composite rate. These are rejected back to the hospital with the message, "This change requires an xx7 debit-only or xx8 cancel-only request from you. Late charges are not acceptable for inpatient PPS ancillaries, inpatient accommodations in any facility, services on the same day as outpatient surgery subject to the ASC payment limitation, services on the same day as services subject to OPPS, or ESRD services included in the composite rate."
- When an xx5 suspends as a duplicate, (dates of service equal or overlapping, provider ID equal, HICNs equal, and patient surname equal), the FI must determine the status of the original paid bill. If it is denied, the FI must deny the late charge bill.
- If an xx5 does not suspend as a potential duplicate, the FI rejects it back to the provider with the message, "No original bill paid. Please combine and submit a single original bill (xx1)."

- If the original bill was approved and paid, the FI compares the revenue codes on the original paid bill with the associated late charge bill:
    - For all providers (any bill type), if any are the same, and are revenue codes 41x, 42x, 43x, 44x, 63x, 76x, or 91x, the FI rejects the bill back to the provider with the message, "You must submit an adjustment (xx7) to the original paid bill. Revenue codes subject to utilization review are duplicated on the late charge bill."
    - For HHA services not under a plan of care (bill type 34x), the FI must apply the same logic for the following additional revenue codes. If any are the same and are revenue codes 27x, 29x, 55x, 56x, 57x, 58x, 59x, 60x, or 63x, the FI rejects the bill back to the provider with the message, "You must submit an adjustment (xx7) to the original paid bill. Revenue codes subject to utilization review are duplicated on the late charge bill."
    - For hospital outpatient services (bill type 13x only), the FI must apply the same logic for the following additional revenue codes. If any are the same and are revenue codes 255, 32x, 33x, 34x, 35x, 40x, 62x, 73x, 74x, 92x, or 943, the FI rejects the bill back to the hospital with the message, "You must submit an adjustment (xx7) to the original paid bill. Revenue codes subject to utilization review are duplicated on the late charge bill."
    - For RDFs (bill type 72x or 73x), the FI must apply the same logic for the following additional revenue codes; if any are the same and are revenue codes 634, 635, 82x, 83x, 84x, 85x, or 88x, the FI rejects the bill back to the provider with the message, "You must submit an adjustment (xx7) to the original paid bill. Revenue codes subject to utilization review are duplicated on the late charge bill."
- If the late charges bill relates to two or more "original" paid bills, and one of these is denied, the FI must suspend and investigate the late charge bill.
- The FI must compare total charges on the original paid bill with those on the associated late charge bill, and suspend and investigate any xx5 bill type with total charges in excess of those on the original paid bill. This edit suggests the provider may have rebilled the already paid services.

The FI may decide to perform additional edits on late charge bills.

130.2 - Inpatient Part A Hospital Adjustment Bills
(Rev. 1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

For UB-04 adjustment requests, the hospital places the ICN/DCN of the original bill in the appropriate form locator. Information regarding the form locator number that corresponds to the ICN/DCN field and a table to crosswalk UB-04 form locators to the 837 transaction is found in Chapter 25. Where payment is handled through the cost reporting and settlement processes, the hospital accumulates a log for those items not requiring an adjustment request. For cost settlement, the FI pays on the basis of the log. This log must include:

- Patient name;
- HICN;
- Dates of admission and discharge, or from and thru dates;
- Adjustment in charges (broken out by ancillary or routine service); and
- Any unique numbering or filing code necessary for the hospital to associate the adjustment charge with the original billing.

NOTE: Hospitals in Maryland, which are not paid under PPS or cost reports, submit an adjustment request for inpatient care of $500 or more, and keep a log as described above for lesser amounts. Because there are no adjustment requests, the FI enters the payment amounts from the summary log into the PPS waiver simulation and annually pays the items on the log after the cost report is filed.

After cost reports are filed, the FI makes a lump sum payment to cover these charges as shown on the summary log. The hospital uses the summary log for late charges only under cost settlement (outpatient hospital), except in Maryland.

Maryland and cost hospitals are required to meet the 27-month timeframe for timely filing of claims, including late charges.

For all adjustments other than QIO adjustments (e.g., provider submitted and/or those the FI initiates), the FI submits an adjustment request to CWF following its acceptance of the initial bill. To verify CMS's acceptance, the FI can submit a status query.

Under inpatient hospital prospective payment, adjustment requests are required from the hospital where errors occur in diagnosis and procedure coding that changes the DRG, or where the deductible or utilization is affected. A hospital is allowed 60 days from the date of the FI payment notice (remittance advice) for adjustment requests where diagnostic or procedure coding was in error resulting in a change to a higher weighted DRG. Adjustments reported by the QIO have no corresponding time limit and are adjusted automatically by the FI without requiring the hospital to submit an adjustment request. However, if diagnostic and procedure coding errors have no effect on the DRG, adjustment requests are not required.

Under PPS, for long-stay cases, hospitals may bill 60 days after an admission and every 60 days thereafter if they choose. The FI processes the initial bill through Grouper and PRICER. When the adjustment request is received, it processes it as an adjustment. In this case, the 60-day requirement for correction does not apply.

130.2.1 - Tolerance Guidelines for Submitting Inpatient Part A Hospital Adjustment Requests

(Rev. 1, 10-01-03)

A3-3664.1.A

When a bill is submitted and the hospital or the FI discovers an error, the hospital submits an adjustment request using the CMS-1450, if the error is a change in the:

- Number of inpatient days (including a change in the length of stay, or a different allocation of covered/noncovered days);
- Blood deductible;
- Inpatient cash deductible of more than $1;
- Servicing hospital;

For inpatient hospital bills paid under PPS, CMS also requires an adjustment request for a change in:

- Discharge status in a PPS hospital;
- The DRG code; or
- Outlier payment amount.

The hospital submits most adjustment requests as debits, using bill type xx7.

Also, it submits a debit-only adjustment request to the FI if it previously submitted an interim bill for a PPS hospital stay or wishes to change the number of days in any inpatient stay.

The FI then submits the adjustment to CWF. An adjustment from the QIO for any of the above also requires a submission to CMS via CWF.

If an adjustment the hospital initiates results in a change to a higher weighted DRG, the FI edits the adjustment request to insure it was submitted within 60 days of the date of the remittance for the claim to be adjusted. If it is, the FI processes the claim for payment. If the remittance date is more than 60 days prior to the receipt date of the adjustment request and results in a change to a lower weighted DRG, the FI processes the claim for payment and forwards it to CWF.

130.3 - SNF Part A Adjustments
(Rev. 1, 10-01-03)

130.3.1 - Tolerance Guides for Submitting SNF Inpatient Adjustment Requests
(Rev. 1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)
SNF-562

SNF inpatient adjustment requests adhere to the same billing instructions as non-inpatient adjustment requests with the following changes. When an initial bill has been submitted and the provider or FI discovers an error on the bill, an adjustment request is submitted if the change involves one of the following:

- A change in the Part B cash deductible of more than $1.00
- A change in the number of inpatient days;

- A change in the blood deductible;
- A change in provider number;
- A change in coinsurance which involves an amount greater than $1.99;
- A change in the HIPPS code to correct a data input error or,
- Effective for changes for services June 1, 2000, change in HIPPS code due to an MDS correction. (Such adjustments are required within 120 days of the through date on the initial bill.) **NOTE:** See Chapter 6, Section 35 for information on submitting adjustments to HIPPS codes resulting from MDS corrections.

Late charge billings (type of bill xx5) are not acceptable for SNF PPS Part A services. The reason for an adjustment (Claim Change Reasons) is reported in one of the condition code fields. Claim Change Reason Codes applicable to SNFs are:

D0	Changes to Service Dates	D6	Cancel only to repay a duplicate OIG payment
D1	Changes to Charges	D7	Change to Make Medicare Secondary Payer
D2	Changes in Revenue codes/ HCPCS - HIPPS	D8	Change to Make Medicare Primary Payer
D4	Changes in Grouper code	D9	Any Other Change
D5	Cancel to correct HICN or Provider ID	E0	Change in Patient Status

The SNF selects the one code that best describes the change reason. An adjustment may contain multiple changes even though only one reason code is reported.

130.3.2 - SNF Inpatient Claim Adjustment Instructions

(Rev. 1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

1. Type of Bill is 217, (replacement bill).

2. Internal Control Number (ICN)/Document Control Number (DCN) Required. All providers requesting an adjustment to a previously processed claim must insert the ICN/DCN of the claim to be adjusted. Payer A's ICN/DCN must be shown on line "A". Similarly, the ICN/DCN for Payer's B and C must be shown on lines B and C respectively.

3. Appropriate Claim Change Reason Code.

4. The provider must submit an entire replacement debit.

Note: Information regarding the form locator numbers that correspond to these data element names and a table to crosswalk UB-04 form locators to the 837 transaction is found in Chapter 25.

130.3.3 - Patient Does Not Return From SNF Leave of Absence, and Last Bill Reported Patient Status as Still Patient (30)

(Rev. 1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

Where the patient does not return from a leave of absence, regardless of the reason, the SNF must submit a discharge bill showing the date of discharge as the date the individual actually left. If the patient status was reported as "30" (still patient) on an interim bill and the patient failed to return from a leave of absence within 30 days, including the day leave began, or has been admitted to another institution at any time during the leave of absence, the SNF must submit an adjustment request to correctly indicate the day the patient left as the date of discharge. (A beneficiary cannot be an inpatient in two institutions at the same time.) This closes the open admission on the patient's utilization record.

NOTE: Home health or outpatient services provided during a leave of absence do not affect the leave and no discharge bill is required.

EXAMPLE l:

The beneficiary goes on a leave of absence on January 3, expecting to return on January 10. On January 6, the SNF receives word that the patient died on January 5. The SNF submits a discharge bill showing January 3 as the date of discharge.

EXAMPLE 2:

The beneficiary goes on a leave of absence on February 6, expecting to return on February 12. However, the beneficiary does not return on February 12 as expected and the SNF cannot determine whether the beneficiary will return. The SNF submits a discharge bill showing February 6 as the date of discharge as soon as practical, or after 30 days have elapsed from the day the leave began. If an interim bill had been submitted showing the beneficiary in "still patient" status as of February 6 or later, the SNF submits an adjustment request showing February 6 as the discharge date. The advantage of delaying the discharge bill for 30 days is that it will make unnecessary a new admission notice in the event the beneficiary returns before 30 days have elapsed.

EXAMPLE 3:

The beneficiary goes on a leave of absence on March 4, and is expecting to return April 1 but does not. The SNF submits a discharge bill showing March 4 as the date of discharge since the beneficiary did not return within the 30-day period.

130.4 - Hospital and SNF Part B Adjustment Requests

(Rev. 1, 10-01-03)

130.4.1 - Guidelines for Submitting Adjustment Requests

(Rev. 1, 10-01-03)

SNF-562, SNF-562.A

When an initial bill for outpatient services or inpatient Part B services has been submitted and the provider or the FI discovers an error, the provider submits an adjustment request to the FI. The FI submits the adjustment to CMS if there is a change in:

- The Part B cash deductible of more than $1;
- Covered charges of more than $1 on bills for surgery or other outpatient procedures;
- The servicing provider;
- The Part B blood deductible;
- The coinsurance amount greater than $1.99; or
- Procedure codes.

130.5 - Home Health Adjustments

(Rev. 1, 10-01-03)

130.5.1 - Submitting Adjustment Requests

(Rev. 1, 10-01-03)

HH-445

A home health agency submits a corrected Form CMS-1450 if any of the following apply:

- A change in provider number;
- A change in coinsurance involves an amount greater than $1.99; or
- A change in visits (decrease or increase).

Where there are money adjustments other than a coinsurance amount greater than $1.99, the agency records the difference on a record sufficiently documented to establish an accounting data trail, including patient's name and HICN, first and last dates of services, and any unique numbering or filing code necessary to associate the adjustment charge with the original billing.

A number of conditions can cause the episode payment to be adjusted. Both RAPs and claims may be cancelled by HHAs if a mistake is made in billing (TOB 328), though episodes will be cancelled in CWF as well. Adjustment claims may also be used to change information on a previously submitted claim (TOB 327), which may also change payment. RAPs can only be cancelled, not adjusted, but may be re-billed after cancellation.

130.6 - Adjustments to Reprocess Certain Claims Denied Due to an Open Common Working File (CWF) Medicare Secondary Payer (MSP) Group Health Plan (GHP) Record Where the GHP Record Was Subsequently Deleted

(Rev. 686, Issued: 09-23-05; Effective: 01-01-06; Implementation: 01-03-06)

Effective January, 3, 2006 CWF will implement an unsolicited response to reprocess certain claims denied due to an open CWF MSP GHP record where the GHP record was subsequently determined to be invalid by the Coordination of Benefits Contractor (COBC) and deleted by the COBC. The COBC identifies and deletes invalid MSP records in the CWF. Upon deletion of an invalid MSP GHP record (MSP Codes 12, 13, 43) the CWF will search the claims history for the period during the 365 calendar days preceding the deletion of the CWF record in order to locate any claims billed to Medicare as primary and denied on the basis of the subsequently deleted CWF MSP GHP record. The CWF will generate an unsolicited response with a trailer containing the identifying information regarding any such claims found. The unsolicited response will have all the necessary information to identify the claim, including the Document Control Number/Internal Control Number, Health Insurance Claim number, beneficiary name, and date(s) of service. The CWF will electronically transmit this unsolicited response to the claims processing contractor(s) that originally processed the claim(s). The previously denied claim(s) will not be canceled and will remain on CWF claims history, pending subsequent adjustment.

Upon receipt of the unsolicited response, the shared system software will read the claim information in the new trailer for each claim and perform an automated adjustment to each claim. The claim(s) must be adjusted for all non-reimbursed/claim denials that were based upon the MSP GHP record that was just deleted. The shared system will hold the adjusted claims for 5 business days to allow the COBC to make additional corrections to the MSP files in the CWF. After a 5 business day hold, the shared system will release the adjustments. The adjustments shall be subject to all applicable edits as the original claim(s) and sent to the CWF, so that the claim(s) on the CWF history are replaced with the adjusted claim(s) records.

140 - Fiscal Intermediary (FI) Edits Affecting Multiple Bill Types

(Rev. 620, Issued: 07-29-05, Effective: 01-03-06, Implementation: 01-03-06)

140.1 - Threshold Edit for Outpatient and Inpatient Part B Claims

(Rev. 620, Issued: 07-29-05, Effective: 01-03-06, Implementation: 01-03-06)

Effective for claims received on or after January 1, 2006, intermediaries shall edit for outpatient and inpatient Part B claims that meet or exceed a reimbursement amount of $50,000. The edit shall be applied to the following providers and bill types:

Provider Type	Types of Bills
• Hospitals	12X, 13X, 14X

- Skilled Nursing Facilities 22X, 23X
- Home Health Agencies 32X, 33X, 34X
- Religious Nonmedical Health Care Institutions 43X
- Rural Health Clinics 71X
- Renal Dialysis Facilities 72X
- Federally Qualified Health Centers 73X
- Outpatient Rehabilitation Facilities 74X
- Comprehensive Outpatient Rehabilitation Facilities 75X
- Community Mental Health Centers 76X
- Hospice Providers 81X, 82X
- Non-OPPS Hospitals Ambulatory Surgery 83X
- Critical Access Hospitals 85X

The FIs shall suspend those claims receiving the threshold edit for development and contact providers to resolve billing errors. If the FI determines that the reimbursement is excessive and claim corrections are required, the FI shall return the claim to the provider. If the FI determines that the billing is accurate and the reimbursement is not excessive, the FI shall override the edit and submit the claim to the Common Working File (CWF)

150 - Limitation of Liability Notification and Coordination With Quality Improvement Organizations (QIOs)

(Rev. 632, Issued: 07-29-05, Effective: 01-03-06, Implementation: 01-03-06)

The longstanding relationship between QIOs and fiscal intermediaries (FIs) is defined in regulations at 42 CFR 476.80. Generally, these regulations require QIOs and FIs to have an agreement under which:

- QIOs inform FIs of the results of DRG validation of hospital inpatient claims
- QIOs inform FIs of initial determinations of cases subject to preadmission review and any changes to these determinations
- FIs ensure they do not pay claims subject to initial determinations until they receive notice from the QIO

- QIOs and FIs exchange data or information and otherwise coordinate to perform their functions.

More recently, this relationship was expanded by regulations regarding expedited determinations, found in 42 CFR 405, sections 1200-1208. The following subsections provide additional detail on the coordination between these parties. They also describe how various Medicare provider types reflect decisions of QIOs on claims they submit to Medicare FIs and how these decisions may affect the liability of Medicare beneficiaries for payment.

150.1 - Limitation on Liability - Overview

(Rev. 632, Issued: 07-29-05, Effective: 01-03-06, Implementation: 01-03-06)
A3-3674.1
HO-414.6

Chapter 30, of this manual has a complete explanation of the limitation of liability provision. However, the basic premise of the limitation on liability provision (§1879 of the Act) is that beneficiaries and providers who "did not know, and could not reasonably have been expected to know, that payment would not be made for such items(s) or service(s) item(s) and/or service(s)" are protected from liability. Where the provider had such knowledge, such that the 1879 limitations on liability do not apply, liability falls upon the provider (i.e., the provider cannot charge the beneficiary for such services when aware no program payment will be made).

Medicare requires providers to notify beneficiaries when they face financial liability, so they can make informed choices.

150.2 - Hospital Claims Subject to Hospital Issued Notices of Noncoverage

(Rev. 632, Issued: 07-29-05, Effective: 01-03-06, Implementation: 01-03-06)

Hospitals must issue the HINN for inpatient hospital services, form prior to delivering care, and must deliver the form properly, so that a beneficiary knowingly assumes liability. Instructions for the HINN are found in CMS Transmittal 594, and apply in specific cases to Part A services furnished by hospitals.

150.2.1 - Scope of Issuance of Hospital Issued Notices of Noncoverage (HINNs)

(Rev. 632, Issued: 07-29-05, Effective: 01-03-06, Implementation: 01-03-06)
HO-414.3, .4

Inpatient hospitals are required to issue HINNs to beneficiaries in a variety of circumstances defined in Chapter 30 of this manual. Hospitals should refer to section 80 of that chapter for further instructions on HINNs.

NOTE: Hospitals submit bills for all inpatient stays, including those for which no payment can be made. Although no monies are involved with no-payment bills, a claim is required because hospitalization could extend a Medicare beneficiary's benefit period, or coinsurance or deductible may be due. The hospital is not required to issue a HINN when it does not plan to bill the beneficiary (or their representative) for item(s) or service(s). However, applicable coinsurance and deductibles are always charged to the beneficiary when care is provided no matter what party is liable for payment, and no liability notification is required for these collections.

150.2.2 - General Responsibilities of QIOs and Fiscal Intermediaries (FIs) Related to HINNs

(Rev. 632, Issued: 07-29-05, Effective: 01-03-06, Implementation: 01-03-06)
A3-3674.2

Publication 100-10, The Quality Improvement Organization Manual, Chapter 7, provides detailed instructions regarding QIO responsibilities and procedures related to HINNs.

The FI is responsible for making liability determinations in other cases (e.g., eligibility and reductions of payment). However, the FI adjudicates claims, makes payment and sends beneficiaries Medicare Summary Notices in all cases, reflecting both QIO and FI determinations on liability. This joint responsibility requires that the QIO notify the FI of its denial determinations, all preadmission determinations, and diagnostic or procedural coding changes. The FI does not issue a denial notice to the beneficiary or the hospital for cases that have been reviewed by the QIO. The QIO notifies the beneficiary and hospital.

NOTE: QIO determinations are binding and cannot be reversed by the FI.

150.2.3 - Billing and Claims Processing Requirements Related to HINNs

(Rev. 1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

Where QIO review is done prior to billing (preadmission or admission HINN), the hospital reports the results of the QIO's review on the claim using special indicators. A set of condition codes were created to reflect these reviews. These codes, C1- C7, are known as the QIO approval indicator codes. Information regarding the form locator numbers that correspond to condition codes and a table to crosswalk UB-04 form locators to the 837 transaction is found in Chapter 25.

The FI reviews these codes and makes determinations as follows:

- Code C1, C3, or C6 - Pay as billed.
- Code C4 - Do not pay, but process a no-payment bill.
- Blank or Code C5 - Return the claim to the provider for QIO review, unless the FI’s agreement with the QIO requires sending it directly to the QIO.

Where the QIO review occurs after FI processing (postpayment review), the QIO reports adjustments to the FI. Currently there is no approved electronic format for this report.

150.3 - Skilled Nursing Facility (SNF), Home Health Agency (HHA), Hospice and Comprehensive Outpatient Rehabilitation Facility (CORF) Claims Subject to Expedited Determinations

(Rev. 632, Issued: 07-29-05, Effective: 01-03-06, Implementation: 01-03-06)

In short, SNFs, HHAs, hospices and CORFs must give notice to Medicare beneficiaries of their right to expedited determinations when their period of covered care ends. Expedited determinations allow beneficiaries to challenge/appeal their provider's decisions to discharge, whereas the standard appeal process available after a claim is adjudicated allows beneficiaries to dispute payment denials. Detailed instructions regarding expedited determination notices are found in CMS Transmittal 594.

150.3.1 - Scope of Issuance of Expedited Determination Notices

(Rev. 632, Issued: 07-29-05, Effective: 01-03-06, Implementation: 01-03-06)

Expedited determination notices are required prior to discharge when Medicare covered care has been occurring for some type of duration, such as a stay in an inpatient facility, or a period of services delivered under a plan of care supported by a physician order. Generally, intermittent items or services covered under Part B do not trigger the right to expedited determinations, since there is no continuous care to end. Expedited determinations are available to beneficiaries for each of the specified provider types as follows:

HHAs: Provider initiated discharges for coverage reasons from HH services under a home health plan of care (types of bill 32x and 33x) are subject to expedited determination notices. Home health services billed on a 34x type of bill are included if there is a therapy plan of care, but not when the HHA is acting as a durable medical equipment supplier in one-time or sporadic delivery of equipment.

SNFs: Provider initiated discharges for coverage reasons associated with SNF and swing bed inpatient claims (types of bill 18x, 21x and 22x) are subject to expedited determination notices.

Hospices: Provider initiated discharges for coverage reasons from hospice services (types of bill 81x and 82x), whether in inpatient or home care settings, are subject to expedited determination notices. Even though revocation represents an end of covered hospice care, it cannot trigger an expedited determination since it is the beneficiary's, not the provider's, choice to revoke. Hospice discharges related to qualification/coverage specific to the benefit would be rare cases where a beneficiary previously certified as terminally ill is judged no longer to be terminal.

CORFs: Provider initiated terminations of all covered CORFs services (type of bill 75x) provided under a therapy plan of care are subject to expedited determination notices. CORF services not provided under a plan of care, such as injections, are not included.

Therapy services provided by outpatient rehabilitation facilities (type of bill 74x) or therapy services in hospital outpatient departments are not included.

Expedited determinations notices are not required when discharge is unrelated to coverage.

150.3.2 - General Responsibilities of QIOs and FIs Related to Expedited Determinations

(Rev. 632, Issued: 07-29-05, Effective: 01-03-06, Implementation: 01-03-06)

A. QIO Role

QIOs review expedited determination notices providers give beneficiaries, both as part of making decisions relative to coverage and to assure providers have given valid notice. The QIO is responsible for establishing contact with the provider, so that the beneficiary's medical records can used in making a determination, although QIOs can still make such decisions even if records are not available. The QIO makes a decision on coverage in answer to the beneficiary's request for review, relaying this decision back to the involved parties. If the beneficiary does not accept the QIO determination, they may request a reconsideration from a Qualified Independent Contractor (QIC).

B. Intermediary Role

Intermediaries support beneficiaries and providers through an awareness of the expedited determination process and by performing routine duties potentially affected by this process--liability notice oversight, claims processing and medical review. In the initial implementation of expedited determinations, FIs need to coordinate with QIOs regarding the outcome of QIO reviews. As providers begin reporting the outcomes of QIO reviews on claims, the need for this coordination will diminish.

Intermediary medical review should never repeat or contradict the results of QIO review regarding coverage, since this would be duplicative and QIO decisions are binding, and QIOs are bound by the same coverage policy in making their determinations--even local policy. But the scope of these QIO decisions is limited to discharge, and medical review examines a much broader range of potential issues and periods of care. For example, a monthly SNF claim could include a discharge reviewed by a QIO, but it also contains other days of billing not related to discharge—the non-discharge period is not considered by the QIO, and would still be subject to medical review.

150.3.3 - Billing and Claims Processing Requirements Related to Expedited Determinations

(Rev. 1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

As noted above, the outcome of expedited determinations and reconsiderations will be reported on Medicare claims to assure intermediary adjudication of claims is consistent with QIO/QIC decisions. Note that the expedited review process is always completed prior to billing, and therefore does not directly affect established billing procedures, even demand billing, other than the use of indicators described below.

Special indicators are used on claims to reflect the outcome of QIO expedited determinations and QIC reconsiderations. Before the creation of the expedited review process, QIO related determinations were reflected only on hospital claims. A set of condition codes were used to reflect these determinations. These codes, C1- C7, are known as the QIO approval indicator codes.

With the advent of the expedited determination process, these QIO approval indicators are relevant to types of bill other than inpatient hospital claims. The QIO approval indicator codes described below are valid for Medicare billing on the following types of bill:

18x, 21x, 22x, 23x, 32x, 33x, 34x, 75x, 81x, 82x.

Since QIO expedited decisions and QIC reconsideration decisions have the same effect on providers and beneficiaries, the same QIO approval indicator codes will be used to report a decision by either entity. Providers should note that no indicators are required on discharge claims in the case where a generic notice is provided and the beneficiary does not request an expedited determination.

A Reporting of QIO/QIC Decisions Upholding a Discharge

Providers must also report indicators on claims when they receive notification of decisions which uphold the provider's decision to discharge the beneficiary from Medicare covered care. In these cases, providers submit a discharge claim for the billing period that precedes the determination according to all applicable claims instructions plus one additional data element. Providers must annotate these claims with condition code C4, defined as "Services Denied."

Beneficiaries are protected from liability for the period from the delivery of the expedited notice, usually two days before the end of coverage, to the end of the covered period written on the notice if the beneficiary requests an expedited determination timely. If the beneficiary does not request the determination timely, or if the determination process at the QIO is delayed, the beneficiary may be liable for services provided from the day after the end of the covered period until the date of the actual discharge.

In cases where the beneficiary may be liable, in addition to reporting condition code C4 providers must also report occurrence span code 76, defined as "patient liability period," along with the days of liability that have been incurred. Line items with dates of service falling within this patient liability period are reported with noncovered charges and, if they require HCPCS coding, with modifier –TS. Intermediaries will deny these lines and hold the beneficiary liable.

In certain cases, an Advance Beneficiary Notice (ABN) may be issued simultaneously or immediately following the issuance of an expedited determination notice. These ABNs would pertain to continued services that the beneficiary wishes to receive despite the provider's intent to discharge the beneficiary. Any required physician orders continue to be needed for the services to continue. If these ABN situations result in a beneficiary's

request for a demand bill to Medicare regarding continuing services after the QIO/QIC has upheld the discharge, providers must report condition code C4 on the demand bill. The demand bill must otherwise be prepared according to all other applicable instructions.

B Reporting of QIO/QIC Decisions Not Upholding a Discharge

When providers are notified of QIO/QIC decisions that authorize continued Medicare coverage and do not specify a coverage ending date, they must submit a continuing claim for the current billing or certification period according to all claims instructions for the applicable type of bill, plus a single additional data element. Providers must annotate these claims with condition code C7, which is defined "QIO extended authorization." This indicator will alert FIs/RHHIs that coverage of the services on the claim has already been subject to review.

In the circumstance, expected to be rare, when providers are notified of QIO/QIC decisions which authorize continued Medicare coverage only for a limited period of time, they must submit claims as follows:

- If the time period of coverage specified by the QIO/QIC extends beyond the end of the normal billing or certification period for the applicable type of bill, providers submit a continuing claim for that period according to all applicable claims instructions plus two additional data elements. Providers must annotate these claims with condition code C3, which is defined "QIO partial approval" and with occurrence span code M0, which is defined "QIO approved stay dates", along with the following dates—the beginning date of the coverage period provided by the QIO/QIC, and the statement through date of the claim.

- If the time period of coverage specified by the QIO/QIC does not extend to the end of the normal billing or certification period for the applicable type of bill, providers submit a discharge claim according to all applicable claims instructions plus two additional data elements. Providers must annotate these claims with condition code C3, which is defined "QIO partial approval" and with occurrence span code M0, which is defined "QIO approved stay dates" and the dates provided by the QIO/QIC.

NOTE: Regarding any decision that does not uphold a discharge, QIO/QIC decisions authorizing extended coverage cannot authorize delivery of services if there are not also the required physician orders needed to authorize the care.

C Billing Beneficiaries in Cases Subject to Expedited Determinations

Providers should note a significant difference between the use of expedited determination notices and the use of ABNs. As described in Claims Processing Manual, Chapter 1, section 60.3.1, in ABN or HHABN situations, all providers other than SNFs can bill beneficiaries for services subject to a demand bill while awaiting a Medicare determination on the coverage of the services. The same is not true in expedited

determination situations. When a beneficiary requests an expedited determination timely, no funds may be collected until the provider receives notification of the QIO/QIC decision.

D Reporting Provider Liability Situations

Providers may be liable as a result of two specific situations in the expedited review process:

(1) if the provider is not timely in giving information to the QIO; and

(2) if the provider does not give valid notice to the beneficiary.

Since both these events occur after the point the provider has already determined discharge is imminent, there may be no actual liability, since there may be no medical need for additional care. However if services are required, and either of these liability conditions apply, such services should be billed as noncovered line items using the –GZ modifier, which indicates the provider is liable, consistent with Section 60.4.2 of this chapter.

160 - Identifying Institutional Providers

(Rev. 771, Issued: 12-02-05, Effective: 01-03-06, Implementation: 01-03-06)

Effective January 3, 2006, the six position alpha-numeric provider number will begin transitioning to the ten position numeric "National Provider Identifier" (NPI). The following provides instructions on how the provider number (OSCAR) will be transitioned to the NPI:

May 23, 2005 through January 2, 2006	Providers continue to submit the current six position alpha-numeric provider number. Any claims submitted with only the NPI number will be returned as unprocessable.
January 3, 2006 through October 1, 2006	Providers continue to submit the current six position alpha-numeric provider number. The NPI number may also be submitted but must be present with the current provider number.
October 2, 2006 through May 22, 2007	Providers may submit the current six position alpha numeric provider number and/or the NPI number.
Beginning May 23, 2007	Providers must only submit the NPI number.

References to the six position alpha-numeric number or OSCAR number found throughout the chapters of the Medicare Claims Processing Manual, on an ongoing basis, are supplied only for the purpose of CMS internal processing. Therefore, these references are documented as "for CMS use only".

NOTE: All other references to "provider number" in the chapters that follow refer to the usage of identifiers per the table above.

160.1 - Reporting of Taxonomy Codes (Institutional Providers)

(Rev. 1133, Issued: 12-19-06; Effective: 01-01-07; Implementation: 01-02-07)

Institutional providers that currently bill Medicare using more than one legacy identifier in order to identify subparts of their facility are required to submit a taxonomy code on all of the claims they submit to Medicare. Medicare legacy identifiers are six-digit Medicare provider numbers, also called OSCAR numbers. Taxonomy codes shall be reported by these facilities whether or not the facility has applied for individual NPIs for each of their subparts. Institutional providers that do not currently bill Medicare for subparts are not required to use taxonomy codes on their claims to Medicare. The following table supplies the crosswalk from the OSCAR number to the appropriate taxonomy code based on the provider's facility type:

OSCAR Provider Type	OSCAR Coding	Taxonomy Code
Short-term (General and Specialty) Hospitals	0001-0879 *Positions 3-6	282N00000X
Critical Access Hospitals	1300-1399 *	282NC0060X
Long-Term Care Hospitals	2000-2299 *	282E00000X
Hospital Based Renal Dialysis Facilities	2300-2499*	261QE0700X
Independent Renal Dialysis Facilities	2500-2899*	261QE0700X
Rehabilitation Hospitals	3025-3099 *	283X00000X
Children's Hospitals	3300-3399 *	282NC2000X
Hospital Based Satellite Renal Dialysis Facilities	3500-3699	Type of Bill code 72X + 261QE0700X + different zip code than any renal dialysis facility issued an OSCAR

		that is located on that hospital's campus
Psychiatric Hospitals	4000-4499 *	283Q00000X
Organ Procurement Organization (OPO)	P in third Position	335U00000X
Psychiatric Unit	M or S in third Position	273R00000X
Rehabilitation Unit	R or T in third Position	273Y00000X
Swing-Bed Unit	U, W, Y, or Z in third Position	Type of Bill Code X8X (swing bed) with one of the following taxonomy codes to define the type of facility in which the swing bed is located 275N00000X if unit in a short-term hospital (U), 282E00000X if unit in a long-term care hospital (W), 283X00000X if unit in a rehab facility (Y), 282NC0060X if unit in a critical access hospital (Z)

170 - Payment Bases for Institutional Claims

(Rev. 1526, Issued: 05-30-08, Effective: 07-01-08, Implementation: 07-07-08)

There are many different payment mechanisms that apply to institutional claims. Among these are reasonable cost, prospective payment systems, all of which require at least some bundling of services, and various fee schedules.

170.1 - Services Paid on the Medicare Physician Fee Schedule (MPFS)

(Rev. 1526, Issued: 05-30-08, Effective: 07-01-08, Implementation: 07-07-08)

The following chart shows for selected Types of Bill (TOB) those revenue codes containing (some) services payable on the MPFS.

Services Payable on the MPFS

TOB by Revenue Code

Rev codes															
	12x	IHS 12x	13x	IHS 13x	22x	23x	34x	72x	74x	75x	76x	81x	82x	85x	IHS 85x
030x					X										
031x					X										
032x					X	X									
033x					X	X									
034x					X	X									
036x					X	X									
0401, 0403	X		X		X	X								X	X
0410, 0412, 0419					X	X				X					
042x	X	X	X	X	X	X	X		X	X					

043x	X	X	X	X	X	X	X		X	X					
044x	X	X	X	X	X	X	X		X	X					
046x					X	X									
471	X	X	X	X	X	X									
048x					X	X									
0550, 0559										X					
056x										X					
061x					X	X									
657												X	X		
070x					X	X									
073x					X	X									
074x					X	X									
075x					X	X									
771	X	X	X	X	X	X	X	X		X				X	X

Services Payable on the MPFS

TOB by Revenue Code (continued)

	12x	IHS 12x	13x	IHS 13x	22x	23x	34x	72x	74x	75x	76x	81x	82x	85x	HIS 85x
078x	X	X	X	X										X	X
090x					X	X				X					
091x					X	X				X					
092x					X	X									
0940, 0942, 0949					X	X				X					
096x														X	X
097x														X	X
098x														X	X

170.1.1 – Payments on the MPFS for Providers With Multiple

(Rev.)

180 – Denial of Claims Due to Violations of Physician Self-Referral Prohibition

(Rev. 1578, Issued: 08-15-08, Effective: 01-01-09, Implementation: 01-05-09)

180.1 – Background and Policy

(Rev. 1578, Issued: 08-15-08, Effective: 01-01-09, Implementation: 01-05-09)

Under Section 1877 of the Social Security Act (the Act) (42 U.S.C. §1395nn), a physician may not refer a Medicare patient for certain designated health services (DHS) to an entity with which the physician (or an immediate family member of the physician) has a financial relationship, unless an exception applies. Section 1877 of the Act also prohibits the DHS entity from submitting claims to Medicare, the beneficiary, or any entity for DHS that are furnished as a result of a prohibited referral. The following services are DHS: clinical laboratory services; radiology and certain other imaging services (including MRIs, CT scans and ultrasound); radiation therapy services and supplies; durable medical equipment and supplies; orthotics, prosthetics, and prosthetic devices; parenteral and enteral nutrients, equipment and supplies; physical therapy, occupational therapy, speech-language pathology services; outpatient prescription drugs; home health services and supplies; and inpatient and outpatient hospital services. A "financial relationship" includes both ownership/investment interests and compensation arrangements (for example, contractual arrangements between a hospital and a physician for physician services). The statute and regulations enumerate various exceptions to the physician self-referral prohibition. Violations of the statute are punishable by denial of payment for all DHS claims, refunds of amounts collected for DHS claims, and civil money penalties for knowing violations of the prohibition. Applicable regulations are published at 42 C.F.R. Part 411, Subpart J.

180.2 – Denial Code

(Rev. 1578, Issued: 08-15-08, Effective: 01-01-09, Implementation: 01-05-09)

Prior to the publication of the new CARC #213, there was no specific code to describe claims that are denied based on a violation of the physician self-referral statute at Section 1877 of the Act. A specific code is appropriate so both the providers of DHS and the industry know that claims are being denied based on the non compliance with the physician self-referral prohibitions. This code should be used any time a claim is denied because the physician (or an immediate family member of the physician) has a financial interest in a DHS provider and fails to meet one of the exceptions available in 42 C.F.R. §§411.355-411.357.

Exhibit 1 – Data Element Requirements Matrix (FI)

(Rev. 1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)
A3-3600, Addendum L

Claims will be returned to the provider (RTP) if the following information is incomplete/invalid:

EMC Loop: Segment: Element*	**Data Elements Description**	**Hospital**							**SNF**		
		I	**O**	**H**	**C/OP**	**RHC FQHC**	**HH**	**RD**	**I**	**O**	**RN**
2010AA all segments	Provider Name, Address, Phone #	R	R	R	R	R	R	R	R	R	R
2010AB: all segments	Pay-to Name and Address	NR	NR	NR	NR	NR	NR	NR	R	R	NR
2300:CLM01	Patient Control Number	R	R	R	R	R	R	R	R	R	R
2300:CLM05	Type of Bill	R	R	R	R	R	R	R	R	R	R
2010AA:NM108	Federal Tax Number	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
2300:DTP03:434 qualifier	Statement Covers Period (from-through)	R	R	R	R	R	R	R	R	R	R
2300:QTY01:CA qualifier	Covered Days	R	NR	NR	NR	NR	NR	NR	R	NR	R
2300:QTY01:NA qualifier	Noncovered Days	R	NR	NR	NR	NR	NR	NR	R	NR	R
2300:QTY01:CD qualifier	Coinsurance Days	R	NR	NR	NR	NR	NR	NR	C	NR	C
2300:QTY01:LA qualifier	Lifetime Reserve Days	R	NR	NR	NR	NR	NR	NR	C	NR	C
n/a	Untitled	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR

EMC Loop: Segment: Element*	Data Elements Description	Hospital							SNF		
		I	O	H	C/OP	RHC FQHC	HH	RD	I	O	RN
2010CA:NM103:QC qualifier	Patient's Name	R	R	R	R	R	R	R	R	R	R
2010CA:N301	Patient's Address	R	R	R	R	R	R	R	R	R	R
2010CA:DMG02:D8 qualifier	Patient's Birth Date	R	R	R	R	R	R	R	R	R	R
2010CA:DMG03:D8 qualifier	Patient Sex	R	R	R	R	R	R	R	R	R	R
not used	Patient's Marital Status	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
2300:DTP03:435 qualifier	Admission/Start of Care Date	R	NR	R	NR	NR	R	NR	R	NR	R
2300:DTP03:435 qualifier	Admission Hour	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
2300:CL101	Priority (Type) of Visit	R	NR	NR	NR	NR	NR	NR	R	NR	R
2300:CL102	Source of Referral for Admission or Visit	R	R	NR	NR	NR	R	NR	R	NR	R
2300:DTP03:096 qualifier	Discharge Hour	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
2300:CL103	Patient Discharge Status	R	R	R	NR	NR	R	NR	R	R	R
2300:REF02:EA qualifier	Medical Record Number	C	C	C	C	C	C	C	C	C	C
2300:HI01:BG qualifier	Condition Codes	C	C	C	C	C	C	C	C	C	C

EMC Loop: Segment: Element*	Data Elements Description	Hospital							SNF		
		I	O	H	C/OP	RHC FQHC	HH	RD	I	O	RN
n/a	Untitled	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
2300:HI01:BH	Occurrence Codes and Dates	C	C	C	C	C	C	C	C	C	C
2300:HI01:BI	Occurrence Span Code and Dates	C	C	C	C	C	C	C	C	C	C
2300:REF02:F8 qualifier	Document Control # (DCN)	C	C	C	C	C	C	C	C	C	C
2010BD all segments: QD qualifier	Responsible Party Name (Claim Addressee)	C	C	C	C	C	C	C	C	C	C
2300:HI01:BE qualifier	Value Codes and Amounts	C	C	C	C	C	C	C	C	C	C
2400:SV201	Revenue Code	R	R	R	R	R	R	R	R	R	R
n/a	Revenue Description	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
2400:SV202	HCPCS/Accommodation/HIPPS/Rates	C	C	C	C	C	C	C	C	C	C
2400:DTP03	Service Date	NR	C	C	C	C	C	C	NR	C	C
2400:SV205	Service Units	R	R	R	R	R	R	R	R	R	R
2400:SV203	Total Charges	R	R	R	R	R	R	R	R	R	R
2400:SV207	Noncovered Charges	C	C	C	C	C	C	C	C	C	C
n/a	Untitled	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
2010BC:NM103	Payer Name	R	R	R	R	R	R	R	R	R	R

EMC Loop: Segment: Element*	Data Elements Description	Hospital							SNF		
		I	O	H	C/OP	RHC FQHC	HH	RD	I	O	RN
2010AA:REF01:1A qualifier	Provider Number	R	R	R	R	R	R	R	R	R	R
2300:CLM09	Release of Information	R	R	R	R	R	R	R	R	R	R
2300:CLM08	Assignment of Benefits Certification Indicator	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
2300:AMT02:C5 qualifier	Estimated Amount Due - Payer	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
2010AA:NM103:IL qualifier	Insured’s Name	R	R	R	R	R	R	R	R	R	R
2320:SBR02	Patient’s Relationship to Insured	C	C	C	C	C	C	C	C	C	C
2010BA:NM109	Insured’s Unique Identifier	R	R	R	R	R	R	R	R	R	R
2320:SBR04	Insured’s Group Name	C	C	C	C	C	C	C	C	C	C
2000:SBR02	Insured’s Group Number	C	C	C	C	C	C	C	C	C	C
2300:REF02	Treatment Authorization Code	NR	NR	NR	NR	NR	R	NR	NR	NR	NR
2320:SBR01	Employer Name	C	C	C	C	C	C	C	C	C	C
2300:HI01:BK qualifier	Principal Diagnosis Code	R	R	R	R	R	R	R	R	R	NR
2300:HI01:BF qualifier	Other Diagnosis Codes	C	C	C	C	C	C	C	C	C	NR
2300:HI02:BJ qualifier	Admitting Diagnosis	R	NR	NR	NR	NR	NR	NR	R	NR	NR

EMC Loop: Segment: Element*	Data Elements Description	Hospital							SNF		
		I	O	H	C/OP	RHC FQHC	HH	RD	I	O	RN
2300:H10x-2:ZZ qualifier	Patient's Reason for Visit	NR	C	NR	NR	R	NR	NR	NR	C	NR
2300:HI03:BN qualifier	E-Code	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
2300:HI01:BP qualifier	Principal Procedure Code/Date	C	NR	NR	NR	NR	NR	NR	NR	NR	NR
2300:HI01:BO qualifier	Other Procedure Codes and Dates	C	NR	NR	NR	NR	NR	NR	NR	NR	NR
2310A:NM101:71 qualifier	Attending – NPI/QUAL/ID	R	R	R	R	R	R	R	R	R	NR
2310B:NM109,103,104:72 qualifier	Operating ID – QUAL/NPI/QUAL/ID	C	C	C	C	C	NR	C	C	C	NR
2310C:NM103:73 qualifier	Other ID – QUAL/NPI/QUAL/ID	C	C	C	C	C	NR	C	C	C	NR
2010:N301	Remarks	C	C	C	C	C	C	C	C	C	C
2300:H101x-2	Code-Code Field	C	C	C	C	C	C	C	C	C	C

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R1707CP	03/27/2009	Assignment of Initial Enrollment FQHC'S, ESRD Facilities, and RHC's	04/27/2009	6207
R1706CP	03/27/2009	Manual Clarification for Skilled Nursing Facility (SNF) and Therapy Billing	04/27/2009	6407
R1690CP	02/27/2009	Reporting the National Provider Identifier (NPI) on Claims for Reference Laboratory and Purchased Diagnostic Services Performed Outside the Billing Jurisdiction	03/27/2009	6362
R1677CP	02/13/2009	Shipboard Services Billed to the Carrier and Services Not Provided Within the United States. Rescinds and fully replaces CR 6217.	03/13/209	6327
R1609CP	10/03/2008	Shipboard Services Billed to the Carrier and Services Not Provided Within the United States - Rescinded and replaced by CR 6327, Transmittal 1677	01/05/2009	6217
R1591CP	09/09/2008	ZIP Code Files by Date of Service - Replaced by Transmittal 1591	07/07/2008	5881
R1589CP	09/08/2008	Indicator for the Technical Component of Purchased Diagnostic Services	12/08/2008	6122
R1588CP	09/05/2008	Beneficiary Submitted Claims	08/18/2008	5683
R1586CP	09/05/2008	Pneumococcal Pneumonia, Influenza Virus, and Hepatitis B Vaccines	10/06/2008	6079
R1583CP	08/29/2008	Artificial Hearts	10/06/2008	6185
R1578CP	08/15/2008	Implementation of a New Claim Adjustment Reason Code (CARC) No. 213, "Non-compliance with the Physician Self-referral Prohibition Legislation or Payer Policy"	01/05/2009	6131
R1557CP	07/18/2008	Beneficiary Submitted Claims - Rescinded and replaced by Transmittal 1588	08/18/2008	5683
R1526CP	05/30/2008	Institutional Services Paid on the Medicare	07/07/2008	5990

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		Physician Fee Schedule (MPFS)		
R1522CP	05/30/2008	Charges to Hold a Bed During SNF Absence	06/30/2008	6030
R1486CP	04/04/2008	Exception to 60-Day Limit on Substitute Billing Arrangements for Physicians Called to Active Duty in the Armed Forces Reserves	05/05/2008	5985
R1472CP	03/06/2008	Update of Institutional Claims References	04/07/2008	5893
R1463CP	02/22/2008	ZIP Code Files by Date of Service - Replaced by Transmittal 1591	07/07/2008	5881
R1453CP	02/22/2008	Systems Changes for Prescription Order Numbers for the Competitive Acquisition Program (CAP) for Part B Drugs and Biologicals	07/07/2008	5855
R1432CP	02/01/2008	Medicare Fee for Service Legacy Provider IDs Prohibited on Form CMS-1500 and Form CMS-1450 (UB-04) Claims	04/07/2008	5858
R1421CP	01/25/2008	Update of Institutional Claims References – Rescinded and Replaced by Transmittal 1472	04/07/2008	5893
R1418CP	01/18/2008	New HCPCS Modifiers When Billing for Patient Care in Clinical Research Studies	04/07/2008	5805
R1361CP	11/02/2007	New Patient Status Discharge Code 70 to Define Discharges or Transfers to Other Types of Health Care Institutions not Defined Elsewhere in the UB-04 (CMS-1450) Manual Code List	04/07/2008	5764
R1335CP	09/14/2007	Updating the Internet Only Manual to Include Language “or NPI When Required”	10/01/2007	5708
R1328CP	08/31/2007	Delete References to Reporting of the National Provider Identifier (NPI) on or after May 23, 2007, and Revise References to a “When Required” Date	10/01/2007	5678
R1325CP	08/29/2007	Testing and Implementation of 2008 Ambulatory Surgical Center (ASC) Payment System Changes	01/07/2008	5680
R1312CP	07/20/2007	Timeliness Standards for Processing Other-Than-Clean Claims	01/07/2008	5513

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R1308CP	07/20/2007	Testing and Implementation of 2008 Ambulatory Surgical Center (ASC) Payment System Changes – Replaced by Transmittal 1325	01/07/2008	5680
R1279CP	06/29/2007	Charges for Missed Appointments	10/01/2007	5613
R1250CP	05/25/2007	Implementation of the Carrier Jurisdictional Pricing Rates for All Purchased Diagnostic Service Claims	10/01/2007	5543
R1249CP	05/25/2007	Update to Publication 100-04, Chapters 1 and 15 for ZIP5 and ZIP9 Medicare Zip Code Files.	10/01/2007	5578
R1231CP	04/27/2007	The Use of Benefit's Exhaust (BE) Day as the Day of Discharge for Payment Purposes for the Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) and Clarification of Discharge for Long Term Care Hospitals (LTCH) and the Allowance of No-Pay Benefits Exhaust Bills (TOB 110)	12/03/2007	5474
R1193CP	03/09/2007	Use of 9-Digit Zip Codes for Determining the Correct Payment Locality for Services Paid Under the Medicare Physician Fee Schedule (MPFS) and Anesthesia Services	10/01/2007	5208
R1187CP	02/23/2007	Revisions to Incomplete or Invalid Claims Instructions Necessary to Implement the Revised Health Insurance Form CMS-1500 (8/05)	05/23/2007	5391
R1171CP	02/02/2007	Revisions to the Medicare Physician Fee Schedule (MPFS) Disclosure Format	07/02/2007	5476
R1169CP	02/02/2007	Revision of Editing to Ensure Demand Bills Remain Identifiable in Claims History After Processing	07/02/2007	5248
R1167CP	01/26/2007	Use of 9-Digit Zip Codes for Determining the Correct Payment Locality for Services Paid Under the Medicare Physician Fee Schedule (MPFS) and Anesthesia Services - Replaced by Transmittal 1193	10/01/2007	5208
R1160CP	01/19/2007	Colorectal Cancer Screening Flexible Sigmoidoscopy and Colonoscopy Coinsurance	07/02/2007	5387

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		Payment Change		
R1144CP	12/29/2006	Elimination of CMS-1491 and CMS-1490U Forms	04/02/2007	5390
R1114CP	11/22/2006	Reporting of Taxonomy Codes to Identify Provider Subparts on Institutional Claims	01/02/2007	5243
R1108CP	11/09/2006	Reporting of Taxonomy Codes to Identify Provider Subparts on Institutional Claims	01/02/2007	5243
R1065CP	09/22/2006	Disabling the Revenue/HCPCS Consistency Edit Codes in the Fiscal Intermediary Shared System (FISS)	04/03/2006	4049
R1054CP	09/08/2006	Reporting of Taxonomy Codes to Identify Provider Subparts on Institutional Claims	01/02/2007	5243
R1035CP	08/18/2005	Updating Publication 100-04, Chapter 30 Regarding the CD ROM Initiative for the Annual “Dear Doctor” Mailing	09/18/2006	5214
R1024CP	08/04/2006	Reporting of Taxonomy Codes to Identify Provider Subparts on Institutional Claims	01/02/2007	5243
R989CP	06/23/2006	Correction to CR 4122: Correction of Typographical Error in the Do Not Forward (DNF) Reports	10/02/2006	4394
R980CP	06/14/2006	Changes Conforming to CR 3648 Instructions for Therapy Services - Replaces Rev. 941	10/02/2006	4014
R943CP	05/05/2006	Deported Medicare Beneficiaries	08/07/2006	5051
R941CP	05/05/2006	Changes Conforming to CR 3648 Instructions for Therapy Services	10/02/2006	4014
R930CP	04/28/2006	Benefits Exhaust and No-Payment Billing Instructions for Medicare Fiscal Intermediaries (FIs) and Skilled Nursing Facilities (SNFs)	10/02/2006	4292
R883CP	03/10/2006	Claims Processing Requirements for Medicare Beneficiaries in State or Local Custody Under a Penal Authority – MANUALIZATION	06/12/2006	4352

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R866CP	02/17/2006	Additional Requirements for the Competitive Acquisition Program for Part B Drugs	07/03/2006	4309
R861CP	02/17/2006	Sunset of the Policies for Provider Nomination for an Intermediary and the Provider Requests for a Change of Intermediary – Revision to Publication 100-04, Chapter 1. Section 20	03/17/2006	4286
R850CP	02/10/2006	Change Payment Floor Date for Paper Claims	03/13/2006	4284
R839CP	02/06/2006	Additional Requirements for the Competitive Acquisition Program for Part B Drugs	07/03/2006	4309
R830CP	02/02/2006	Denial of Claims Not Timely Filed	07/03/2006	4041
R771CP	12/02/2005	Revisions to Pub. 100-04, Medicare Claims Processing Manual in Preparation for the National Provider Identifier (NPI)	01/03/2006	4181
R763CP	11/25/2005	Update to Repetitive Billing -- Manualization	N/A	4047
R735CP	10/31/2005	Processing All Diagnosis Codes Reported on Claims Submitted to Carriers	04/03/2006	4097
R717CP	10/21/2005	Disabling the Revenue/HCPCS Consistency Edit Codes in the Fiscal Intermediary Shared System (FISS)	04/03/2006	4049
R712CP	10/14/2005	Correction to Change Request 3949, Section 50.3.3 in IOM to Add 23x Type of Bill	01/03/2006	4116
R711CP	10/14/2005	Update to Repetitive Billing -- Manualization	N/A	4047
R702CP	10/07/2005	Manualization for Physician/Practitioner/Supplier Participation Agreement and Assignment Carrier Claims and Carrier Rules for Limiting Charge	N/A	4030
R686CP	09/23/2005	Common Working File (CWF) Unsolicited Response Adjustments for Certain Claims Denied Due to an Open Medicare Secondary Payer (MSP) Group Health Plan (GHP) Record Where the GHP Record was Subsequently Deleted	01/03/2006	3916
R654CP	08/19/2005	Services Not Provided Within United States	11/17/2005	3781

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R643CP	08/12/2005	Nature and Effect of Assignment on Carrier Claims	11/14/2005	3897
R632CP	07/29/2005	Billing and Claims Processing Instructions for Claims Subject to Expedited Determinations	01/03/2006	3949
R624CP	07/29/2005	Common Working File (CWF) Unsolicited Response Adjustments for Certain Claims Denied Due to an Open Medicare Secondary Payer (MSP) Group Health Plan (GHP) Record Where the GHP Record was Subsequently Deleted	01/03/2006	3916
R620CP	07/29/2005	New Fiscal Intermediary (FI) Edit to Identify Potentially Excessive Medicare Payments	01/03/2006	3925
R593CP	06/24/2005	Disposition of Misdirected Claims to the Carrier	N/A	3838
R552CP	04/29/2005	Changing the Order of Medicare System Edits Affecting Hospice Claims	10/03/2005	3825
R505CP	03/17/2005	Unprocessable Unassigned Form CMS-1500 Claims	07/05/2005	3500
R493CP	03/04/2005	Revision to Chapter 1, and Removal of Section 70 from Chapter 25 of the Medicare Claims Processing Manual	04/04/2005	3671
R492CP	03/04/2005	Adding an Indicator to the National Claims History (NCH) to Indicate that DMERCs, Carriers, and FIs have Reviewed a Potentially Duplicate Claim	07/05/2005	2965
R472CP	02/11/2005	Revisions to Payment for Services Provided Under a Contractual Arrangement - - Carrier Claims Only	03/15/2005	3628
R464CP	02/04/2005	Implementation of the Abstract File for Purchased Diagnostic Tests/Interpretations (Supplemental to CR 3481)	04/04/2005	3694
R454CP	01/28/2005	Definitions of Electronic and Paper Claims	04/04/2005	3653
R443CP	01/21/2005	Unprocessable Unassigned Form CMS-1500 Claims	07/05/2005	3500

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R432CP	01/14/2005	Adding an Indicator to the National Claims History (NCH) to Indicate that DMERCs, Carriers, and FIs have Reviewed a Potentially Duplicate Claim	07/05/2005	2965
R420CP	12/30/2004	Good Cause Waiver of Late Claim Filing Payment Reduction Penalty and Monitoring of Late Claims Submission.	01/31/2005	3549
R416CP	12/23/2004	Interest Payment on Clean Claims Not Paid Timely	01/25/2005	3557
R407CP	12/17/2004	Hospital Billing for Repetitive Services	01/03/2005	3633
R357CP	11/05/2004	Implementation of Coverage of Religious Nonmedical Health Care Institution Items and Services Furnished in the Home, MMA section 706.	04/04/2005	3529
R353CP	11/03/2004	DMERC - Revision to CR 2631 Requirements for DMERC claims	04/04/2005	3261
R345CP	10/29/2004	DMERC – Revision to CR 2631 Requirements for DMERC claims	01/04/2005	3261
R341CP	10/29/2004	Implementation of the Medicare Physician Fee Schedule (MPFS) National Abstract File for Purchased Diagnostic Tests and Interpretations	04/04/2005	3481
R332CP	10/22/2004	New Policy and Refinements on Billing Noncovered Charges to Fiscal Intermediaries (FIs)	04/04/2005	3416
R316CP	10/22/2004	Clarification of Messages in Chapter 1, Section 10.1.1.1 to Match Official Listing on the WPC-EDI Web Site	N/A	3462
R299CP	09/10/2004	Use of Condition Code 44, "Inpatient Admission Changed to Outpatient"	10/12/2004	3444
R296CP	09/03/2004	Payment Denial for Medicare Services Furnished to Alien Beneficiaries Who Are Not Lawfully Present in the United States	N/A	2825
R282CP	08/20/2004	Good Cause Waiver of Late Claim Filing Payment	09/14/2004	3402

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		Reduction Penalty		
R274CP	08/13/2004	Good Cause Waiver of Late Claim Filing Payment Reduction Penalty	09/14/2004	3042
R273CP	08/13/2004	Modification of CMS's Medicare Contingency Plan for HIPAA Implementation	07/06/2004	2981
R270CP	08/03/2004	Update to the Frequency of Billing	01/03/2005	3382
R239CP	07/23/2004	Update to the Frequency of Billing	01/03/2005	3382
R213CP	06/25/2004	Payment to Bank in the Name of a Provider/Physician/Supplier	07/25/2004	3079
R211CP	06/18/2004	Elimination of Regulations for Written Statement of Intent (SOI)	07/19/2004	3310
R207CP	06/18/2004	Expansion of Policy Where Patient is a Member of a Medicare Advantage (MA) Organization For Only a Portion of the Billing Period to Include Inpatient Rehabilitation Facilities (IRF) and Long Term Care Hospitals (LTCH)	07/19/2004	3309
R196CP	06/04/2004	Payment Denial for Medicare Services Furnished to Alien Beneficiaries Who Are Not Lawfully Present in the U. S.	N/A	2825
R170CP	05/07/2004	Filing Request for Payment-Medicare Part B	N/A	2815
R169CP	05/07/2004	Claims Jurisdiction	N/A	2631
R167CP	04/30/2004	Discontinued Use of Revenue Code 0910	10/04/2004	3194
R156CP	04/30/2004	Clarification of payments and billing procedures for hospitals subject to the Maryland Waiver	10/04/2004	3200
R145CP	04/23/2004	Data Element Requirements Matrix - Carrier	05/24/2004	3164
R142CP	04/16/2004	Claims for RRB and UMWA Beneficiaries	N/A	2502
R133CP	04/02/2004	Billing Non-covered Charges to FIs-Clarification to CR 2634	04/16/2004	3115

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R114CP	02/27/2004	Modification of CMS' Medicare Contingency Plan for HIPPA Implementation	07/06/2004	2981
R111CP	02/27/2004	Payment For Services Provided Under a Contractual Agreement	03/12/2004	3083
R091CP	02/06/2004	Revisions to Processing of Non-covered Charges on Certain Home Health Prospective Payment System Claims	07/06/2004	3077
R072CP	01/23/2004	Update of Address for the Railroad Retirement Board (RRB)	02/23/2004	3034
R067CP	01/16/2004	Claims Processing Instructions for Payment Jurisdiction and Payment to Physician for Purchased Diagnostic Tests	04/05/2004	3039
R047CP	12/19/2003	Carrier Data Element Requirements	01/20/2004	2956
R025CP	10/31/2003	Billing Non-Covered Charges to Fiscal Intermediaries Summary and New Instruction	04/05/2004	2634
R001CP	10/01/2003	Initial Publication of Manual	NA	NA

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