CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 3187	**Date: February 6, 2015**
	Change Request 8992

SUBJECT: Language Only Update to Pub 100-04, Chapter 30 for ASC X12 and Claim References

I. SUMMARY OF CHANGES: This CR contains language-only changes for updating ASC X12 and related claims language in Pub 100-04, Chapter 30. There are no new coverage policies, payment policies, or codes introduced in this transmittal. Where reference to carriers and/or intermediaries are present in updated sections these are updated also.

EFFECTIVE DATE: March 6, 2015
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: March 6, 2015

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	30/ 110.3/ Preparation of Denial Notices
R	30/ 110.4/ Bill Processing
R	30/ 130.1/ Applicability of the Limitation on Liability Provision to Claims for Ancillary, Outpatient Provider and Rural Health Clinic Services Payable Under Part B
R	30/ 150.8/ Processing Initial Denials

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

Attachment - Business Requirements

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I. GENERAL INFORMATION

A. Background: This CR contains language-only changes for updating ASC X12 and related claims language in Pub 100-04, Chapter 30.

B. Policy: No new policy.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
8992.1	MACs shall be aware of the proper terminology for MACs.	X	X	X	X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Not applicable.

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

Medicare Claims Processing Manual
Chapter 30 - Financial Liability Protections

110.3 - Preparation of Denial Notices
(Rev.3187, Issued: 02-06-15, Effective: 03-06-15, Implementation: 03-06-15)

The provider and beneficiary notification procedures discussed in §§30 and 40 for determining liability do not change the instructions for the preparation and issuance of denial notices in Medicare Claims Processing Manual, Chapter 21, "Medicare Summary Notices."

Accordingly, in cases where the services are found to be custodial care or not reasonable and necessary, or in the case of HHA services, are denied for technical reasons under §1814(a)(2)(C) or §1835(a)(2)(A), or in the case of hospice services, are denied for technical reasons under §1861(dd)(3)(A):

An MSN denying the service(s) is sent to the beneficiary in cases where only the beneficiary is entitled to limitation on liability for any part of the noncovered stay. The notice advises the beneficiary of the beneficiary's entitlement to indemnification (see §§100.) in the event the provider seeks payment from the beneficiary for the noncovered services. It uses MSN messages 50.36.2:

> It appears that you did not know that we would not pay for this service, so you are not liable. Do not pay your provider for this service. If you have paid your provider for this service, you should submit to this office three things: (1) a copy of this notice, (2) your provider's bill, and (3) a receipt or proof that you have paid the bill. You must file your written request for payment within 6 months of the date of this notice. Future services of this type provided to you will be your responsibility.

All denial notices explain any decision regarding limitation on liability for either the provider, practitioner, or supplier or the beneficiary. (See Chapter 21, "Medicare Summary Notices.")

All denial notices, where either the beneficiary or provider, practitioner, or supplier has been found liable, must state that the provider has a right to a redetermination.

Providers, practitioners, and suppliers do not receive a separate written notification or copy of the MSN. Providers, practitioners, and suppliers must utilize the coding information (e.g., *Remittance Advice* Codes) conveyed via the *R*emittance *A*dvice (RA) to ascertain reasons associated with Medicare claims determinations affecting payment and applicable appeal rights and/or appeals information.

110.4 - Bill Processing
(Rev.3187, Issued: 02-06-15, Effective: 03-06-15, Implementation: 03-06-15)

Where payment is made under the limitation on liability provision, because it was determined that both the provider, practitioner, or supplier and the beneficiary did not know and could not have been expected to know that services were not reasonable and necessary, the usual deductible and coinsurance amounts apply.

When payment under limitation on liability is made for noncovered services, the contractor processes the bill in the same manner as any payment bill for covered services. For institutional services, if both the beneficiary and the provider have liability waived, the *A/B MAC (A)* charges the number of days or visits paid for under the limitation on liability provision to the beneficiary's utilization record. For noninstitutional services, it applies deductible and coinsurance, and, where applicable, statutory limits on services.

For situations where the contractor determines that the provider, practitioner, or supplier knew or should have known that the services were not reasonable and necessary, and the beneficiary did not know and could not have been expected to know that the services were not reasonable and necessary, the beneficiary

qualifies for indemnification and is not responsible for paying deductible and coinsurance charges related to the denied claim. Additionally, where such indemnification is made, the contractor does not charge the beneficiary's Medicare utilization record days, visits, deductibles, or coinsurance (nor does it apply statutory limits, e.g., the psychiatric services Limit) for the denied items and services furnished.

The contractor follows the no-payment procedures in the relevant bill processing instructions in the following cases:

- Either the beneficiary or the provider/practitioner/supplier, or both knew or should have known that services were not covered.

- The provider, practitioner, or supplier knew or should have known that the services were not covered even though the beneficiary did not know. In these cases, the notice to the beneficiary will have informed the beneficiary that, even though no Medicare payment is being made, the beneficiary is not liable for the cost of the services and that the beneficiary may be indemnified for any improper payments the beneficiary made to the provider, practitioner, or supplier.

Where no Medicare payment is made because limitation on liability does not apply, or where payment ceases because of notice in a noncovered case, the normal provisions for no-payment situations apply.

For ancillary and outpatient services billed *by institutional providers*, the provider follows the instructions in Chapter 4 for hospitals, Chapter 7 for SNFs, and Chapter 10 for HHAs to process bills for these types of claims. Further, where ancillary services may not be paid under Part A because they were rendered in connection with a noncovered inpatient stay, the provider may still bill under Part B for ancillary services that may be covered under §1861(s)(3)-(9) of the Act.

130.1 - Applicability of the Limitation on Liability Provision to Claims for Ancillary, Outpatient Provider and Rural Health Clinic Services Payable Under Part B

(Rev.3187, Issued: 02-06-15, Effective: 03-06-15, Implementation: 03-06-15)

The following sections discuss how the limitation on liability provision is applied to claims involving ancillary, outpatient and rural health clinic services billed *to the A/B MAC (A)*, where reimbursement is sought under Part B. The *A/B MAC (A)* determines whether limitation on liability applies to these categories of claims when the basis for the denial is that the services were not reasonable and necessary (under §1862(a)(l) of the Act).

150.8 - Processing Initial Denials

(Rev.3187, Issued: 02-06-15, Effective: 03-06-15, Implementation: 03-06-15)

In any unassigned claim for medical equipment and supplies furnished on or after January 1, 1995, in which the contractor denies payment on the basis of §1862(a)(1), §1834(a)(17)(B), §1834(j)(1), or §1834(a)(15) of the Act, send separate notices to both the beneficiary (a Medicare Summary Notice (MSN)) and the supplier (a remittance advice (RA)).

NOTE: This instruction to send a remittance advice to the supplier in the case of denial of an unassigned claim is a specific requirement of §1834(a)(18)(C) of the Act, incorporated by reference into §1834(j)(4) and §1879(h) of the Act, applicable to denials of claims for medical equipment and supplies furnished on or after January 1, 1995.

If the beneficiary signed an ABN which satisfies the requirements in subsection II.6 and the supplier included a GA modifier on the *claim* to that effect, do not make an automatic finding that the claim should be denied on the basis of §1862(a)(1), §1834(a)(17)(B), §1834(j)(1), or §1834(a)(15) of the Act, merely because the supplier submitted a GA modifier. The fact that an ABN was given to the beneficiary will in no way prejudice the contractor's determination as to whether there is or is not sufficient evidence to justify a denial. In the case where there is an ABN, mail a standard denial MSN notice to the beneficiary. If the beneficiary did not sign an ABN and the supplier included a GZ modifier on the *claim* to that effect, include,

in addition to one of the denial notices in Chapter 21, “Medicare Summary Notices,” the following initial beneficiary notice in the MSN sent to the beneficiary.

A. Initial Beneficiary Notice

(MSN 8.54)

If the supplier should have known that Medicare would not pay for the denied items or services and did not tell you in writing before providing them that Medicare probably would deny payment, you may be entitled to a refund of any amounts you paid. However, if the supplier requests an appeal of this claim within 30 days, a refund is not required until we complete our appeal. If you paid for this service and do not hear anything about a refund within the next 30 days, contact your supplier.

(MSN 8.54) - In Spanish

Si el suplidor hubiera sabido que Medicare no pagaría por los artículos o servicios negados y no le informó por escrito, antes de proveerle los artículos o servicios, que Medicare probablemente negaría el pago, usted podría tener derecho a recibir un reembolso por cualquier cantidad que pagó. Sin embargo, si el suplidor pide una revisión de esta reclamación en 30 días, un reembolso no es requerido hasta que completemos nuestra revisión. Si usted pagó por este servicio y no escucha nada sobre un reembolso en 30 días, comuníquese con su suplidor.

B. Initial Supplier Notice

Include in the notice to the supplier the following;

- The patient’s name and health insurance claim number;
- A description of the item or service by procedure code, date and place of service, and amount of the charge;
- The same denial notice included on the beneficiary’s MSN, (see Chapter 21, “Medicare Summary Notices”); and
- If the supplier submitted a GA modifier (signed ABN obtained), include in the notice to the supplier the following Notice 1. However, if the supplier submitted a “-GZ” modifier (a signed ABN was not obtained), include in the notice to the supplier the following Notice 2.

Notice 1. – Signed Advance Beneficiary Notice Obtained

(Remark Code N124)

Payment has been (denied for the/made only for a less extensive) service/item because the information furnished does not substantiate the need for the (more extensive) service/item. The patient is liable for the charges for this service/item as you informed the patient in writing before the service/item was furnished that we would not pay for it, and the patient agreed to pay.

Or

Notice 2. – Signed Advance Beneficiary Notice Not Obtained

(Remark Code N125)

Payment has been (denied for the/made only for a less extensive) service/item because the information furnished does not substantiate the need for the (more extensive) service/item. If you have collected any amount from the patient, you must refund that amount to the patient within 30 days of receiving this notice. The law permits exceptions to this refund requirement in two cases: if you did not know, and could not have reasonably been expected to know, that Medicare would not pay for this service/item; or if you notified the beneficiary in writing before providing it that Medicare likely would deny the service/item, and the beneficiary signed a statement agreeing to pay.

If an exception applies to you, or you believe the contractor was wrong in denying payment, you should request an appeal of this determination by the contractor within 30 days of receiving this notice. Your request for appeal should include any additional information necessary to support your position. If you request an appeal within 30-days, you may delay refunding to the beneficiary until you receive the results of the appeal. If the appeal determination is favorable to you, you do not have to make any refund. If the appeal is unfavorable, you must make the refund within 15 days of receiving the unfavorable appeal decision.

You may request an appeal of the determination at any time within 120 days of receiving this notice. An appeal requested after the 30-day period does not permit you to delay making the refund. Regardless of when an appeal is requested, the patient will be notified that you have requested one, and will receive a copy of the determination.

The patient has received a separate notice of this denial decision. The notice advises that he or she may be entitled to a refund of any amounts paid, if you should have known that Medicare would not pay and did not tell him or her. It also instructs the patient to contact your office if he or she does not hear anything about a refund within 30 days.

The requirements for refund are in §1834(a)(18) of the Social Security Act (and in §§1834(j)(4) and 1879(h) by cross-reference to §1834(a)(18)). Section 1834(a)(18)(B) specifies that suppliers which knowingly and willfully fail to make appropriate refunds may be subject to civil money penalties and/or exclusion from the Medicare program. If you have any questions about this notice, please contact (contractor contact, telephone number).

Ensure that the telephone number puts the supplier in touch with a knowledgeable professional who can discuss the basis for the denial or reduction in payment.

NOTE: These procedures do not apply where the contractor automatically denies Part B services related to hospital inpatient services denied by the Quality Improvement Organization (QIO). In those cases, the QIO is responsible for notifying the beneficiary and supplier of the refund requirements of §§1834(a)(18), 1834(j)(4), and 1879(h) of the Act and making the refund determination where appropriate.