Medicare
Carriers Manual
Part 3 - Claims Process

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

Transmittal 1759 **Date: JULY 24, 2002**

CHANGE REQUEST 2063

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
3000 – 3001	3-5 – 3-6 (4pp.)	3-5 – 3-6 (4pp.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE:* January 1, 2003
IMPLEMENTATION DATE: January 1, 2003

Section 3000.1, Splitting Claims for Processing, contains new information under the first bullet about an exception to splitting claims for expenses incurred in different calendar years. Deleted language about Durable Medical Equipment (DME) that is paid by monthly installment payments. Deleted language about DME rentals that are diaried for automatic payments.

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

These instructions should be implemented within your current operating budget.

Filing the Request for Payment

3000. DEFINITION OF A CLAIM

A claim is a writing, identifying or permitting the identification of an enrollee, which requests payment for what appears to be Part B medical or other health services furnished by a physician or supplier. (See §5240, in MCM, Part 2 concerning process controls on claims.)

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.

Under this definition, the following do not constitute claims:

- o A claims form not containing sufficient information to permit you to identify the enrollee;
- o Bills or claims forms referring only to services unrelated to medical or other health services;
- o A writing not contained on a claims form and not accompanied by an itemized bill which does not permit you to identify the enrollee and to determine that the medical or other health services were apparently performed by a physician or supplier: and
- o Claims forms, or that portion of a claims form, requesting a payment or coverage determination for services that are not within your claims processing jurisdiction (e.g., misdirected claims/services). Handle misdirected claims/services in accordance with §§3110 and 4267.1, as appropriate.

Under the foregoing definition, the following are examples of claims requiring control:

- o A claim form containing full identifying information;
- o A claim form giving sufficient information for basing requests for further identifying information;
- o Bills for medical or other health services which permit you to identify the enrollee and to determine that the services for which you have claims processing jurisdiction were apparently performed by a physician or supplier. The bills need not be accompanied by a claim form. (See §3040.1.); and
- o A writing not on a claims form or on a bill which requests payment, which permits identification of the enrollee, and which permits you to determine that the medical or other health services in question and for which you have claims processing jurisdiction were apparently performed by a physician or supplier. See §§33l1 and 33l9 for the procedures where additional evidence or information is needed to complete the claim.

3000.1 Splitting Claims for Processing.--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:

o 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.

o A request for payment 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;

o Assigned claims from different physicians/suppliers (excluding group practices and persons or organizations to whom benefits may be reassigned). (See §§3060ff.) Process a separate claim for the services from each physician/supplier. Where the assigned claim is from a person or organization to whom the physicians performing the services have reassigned their benefits in accordance with §§3060ff., process all of the services as a single claim;

o 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.

o 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.

o 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.

o 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.

o 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.

o 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. See §§13310ff. for instructions on reporting claims.

3000.2 Replicating Claims for Processing.--There are no prescribed reasons other than those listed in §3000.l 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 (claims created for any reasons other than those listed in §3000.l) separately. Identify replicate claims and report them in the appropriate categories for claims. (See §§l33l0ff.) Some examples of replicate claims are:

o Additional claims created because of a line item limitation (regardless of the methodology used for coding line items);

o Extra claims created in making partial payments;

o Claims created for carving out individual specialty types of services or for any other occurrence that is not provided for in §3000.l, e.g., unassigned claims containing both services of a podiatrist and services of a physician; and

o 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 (HCFA-l524, HCFA-l528, HCFA-l6l6, and HCFA-2599), the workload must exclude the number of replicate claims produced.

3001. FILING PART B CLAIMS FOR PHYSICIANS' AND SUPPLIERS' SERVICES

A. Methods of Claiming Benefits.--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.

B. Itemized Claims by Patient.--The patient or his/her representative requests direct payment on the basis of an itemized bill (paid or unpaid) (see §§7065 - 7065.2 concerning payment to specified organizations on the basis of a paid bill). For covered services furnished on or after September 1, 1990, physicians and suppliers must complete and submit unassigned Part B claims for beneficiaries who desire Medicare benefit payment determinations.

C. Assignment Method.--The physician/supplier (or the facility or organization to which the physician may reassign benefits (§§3060 - 3060.3)) 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.)

3002. CLAIMS FORMS

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 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.