Medicare Claims Processing Manual

Chapter 1 - General Billing Requirements

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(Rev. 72, 1-23-04)

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Exhibit 1 - Data Element Requirements Matrix (Carrier)

Exhibit 2 - Data Element Requirements Matrix (FI)

01 - Foreword

(Rev. 1, 10-01-03)

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 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)

B3-3100

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 for Services Paid Under the Physician Fee Schedule and Anesthesia Services

(Rev. 1, 10-01-03)

B3-3100.1, B3-3101, B4 2010 partial, B3-4267, R1813B3

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.

When a physician, practitioner, or supplier furnishes physician fee schedule 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 services provided by physicians are within the same carrier jurisdiction that the physicians' office(s)is/are located.

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 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. This applies to all places of service except "home." Carriers 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.

B. Service Provided Outside Office or Home

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 an office setting or a beneficiary's home must include information specifying where the service was provided.

C. Outside Carrier Jurisdiction

Carriers must accept claims that include place of service (POS) home, and/or a POS office, and /or a POS for a facility (other than home or office). If carriers receive a claim that includes more than one facility POS, (not home or office), they must follow resolution procedures in accordance with the instructions in §80. If it receives a significant volume or experiences repeated incidences of misdirected Medicare Physician Fee Schedule claims/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. 1, 10-01-03)

Provided below are separate instructions for processing electronic and paper claims. See §30.2.9 and Chapter 12 for additional information on purchased tests.

A - 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, 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 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.

For example:

- On version 4010/4010A of the ANSI X12N 837 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.

- 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, 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. (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 – Claims/service lacks information that is needed for adjudication, and Remark Code –M77 – "Incomplete/invalid place of service(s)."
>
> 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.

10.1.1.2 - Payment Jurisdiction for Purchased Services

(Rev. 1, 10-01-03)

Diagnostic tests and their interpretations are paid on the MPFS. Therefore, they are subject to the same jurisdictional 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 April1, 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 may receive payment for purchased interpretations. The purchased interpretation must be billed to the carrier that has jurisdiction over the geographic location where the interpretation was performed. Therefore, suppliers must enroll with the carrier that has jurisdiction over the geographic location where the purchased interpretation was performed (i.e., the supplier must submit the interpretation service component to the carrier that would be billed by the interpreting physician if the interpretation hadn't been purchased).

B - Payment Jurisdiction for Physicians for Purchased Diagnostic Tests

Per §30.2.9, physicians may receive payment for purchased diagnostic tests. However, they must bill that test to the carrier that has jurisdiction over the geographic location where the test was performed. Therefore, physicians must enroll with the carrier that has jurisdiction over the geographic location where the test was performed (i.e., the carrier that would be billed by the test supplier if the test component hadn't been purchased).

10.1.1.3 - Payment Jurisdiction for Reassigned Services

(Rev. 1, 10-01-03)

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.

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

Per §30.2.9, suppliers may receive payment for purchased interpretations. The purchased interpretation must be billed to the carrier that has jurisdiction over the geographic location where the interpretation was performed. Therefore, suppliers must enroll with the carrier that has jurisdiction over the geographic location where the purchased interpretation was performed (i.e., the supplier must submit the interpretation service component to the carrier that would be billed by the interpreting physician if the interpretation hadn't been purchased).

B - Payment Jurisdiction for Physicians for Purchased Diagnostic Tests

Per §30.2.9.1, physicians may receive payment for purchased diagnostic tests. However, they must bill that test to the carrier that has jurisdiction over the geographic location where the test was performed. Therefore, physicians must enroll with the carrier that has jurisdiction over the geographic location where the test was performed (i.e., the carrier that would be billed by the test supplier if the test component hadn't been purchased).

10.1.2 - Physician, Supplier, and Group Practice Billing for Multiple Locations

(Rev. 1, 10-01-03)

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, sufficient information must be furnished on the claim concerning the specific location where the services were furnished so that you can determine the correct claims processing jurisdiction and apply the correct physician fee schedule amount. In addition a National Supplier Clearing House number is assigned for each supplier location.

Carriers must accept claims that include place of service (POS) home, and/or a POS office, and /or a POS for a facility (other than home or office). If carriers receive a claim

that includes more than one facility POS, (not home or office), they must continue to follow their current resolution process.

See §20 for Part A providers with multiple locations that bill FIs.

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. 1, 10-01-03)

B3-2312

Items and services which are provided outside the United States are not covered, except for:

- Certain inpatient hospital services provided in Canadian and Mexican hospitals,
- Physician services and ambulance services which are furnished in connection with and during a period of such covered inpatient services (see §10.1.4.1), and
- Certain services rendered on board a ship.

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, and American Samoa. For purposes of services furnished on a ship, it includes the territorial waters adjoining the land areas of the United States.

Services furnished on board a ship in a United States port, or within six 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 furnished more than six hours before arrival at, or after departure 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 §10.1.4.7 for further information regarding shipboard services.

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

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

DMERC claims processing jurisdiction is based on where the service/item was rendered for foreign claims ONLY (claims for eligible Medicare beneficiaries living outside of the United States).

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

(Rev. 1, 10-01-03)

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 and during a period of 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 Canadian ship's 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 an 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
Nova Scotia	75 William Sgt. Terry Drive
Quebec	Hingham, MA 02044-9194

Prince Edward Island	
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. 1, 10-01-03)

B3-2312.4

Because coverage of Part B services furnished in Canada or Mexico 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 Canadian or Mexican services 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 in a Canadian or Mexican hospital."

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	Associated Hospital Services of Maine
Newfoundland	2 Gannett Drive
Nova Scotia	Portland, Maine 04106-6911
Quebec	
Prince Edward Island	
Ontario	Health Care Services Corp.
	233 North Michigan Ave.

	Chicago, IL 60601
Saskatchewan	Blue Cross of Montana
Alberta	3360 10th Avenue, South
Manitoba	P.O. Box 5017
	Great Falls, Montana 59403
British Columbia	Blue Cross of Washington-Alaska, Inc.
Vancouver	7001 220th S.W.
Yukon Territories	Mountlake, Washington 98043

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.)	Blue Cross & Blue Shield of Texas
	901 South Central Expressway
	Richardson, TX 75080

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 Canadian or Mexican 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 Regional Office for the beneficiary's State of residence.

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. 1, 10-01-03)

B3-2312.6

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 Canada or Mexico 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. 1, 10-01-03)

B3-2020.1

Services performed by an American physician aboard an American vessel are covered as physicians' services where:

- The vessel is of American registry;
- The physician is duly registered with the Coast Guard to render the professional services in question; and

- The services are rendered while the ship is within the territorial waters of the United States. (See §10.1.4 for the definition of "territorial waters" and of the term "United States.")

In this case, "physician" is defined as a doctor of medicine, doctor of osteopathy (including osteopathic practitioner), doctor of dental surgery or dental medicine, a chiropractor, or doctor of podiatry or surgical chiropody, or doctor of optometry legally authorized to practice by a State in which he/she performs this function. The services performed by a physician within these definitions are subject to any limitations imposed by the State on the scope of practice.

Except in the case of a Canadian ship's physician who furnishes emergency services in Canadian waters under the conditions in §10.1.4.1.C, a foreign physician who practices medicine on board any foreign vessel cannot be considered a "physician" under the Medicare law and, consequently, any services such physician renders on board ship are not covered under Medicare even though the services were legally rendered within the "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.

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.72, 01-23-04)

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 forwards the claim to the RRB at:

Railroad Retirement Board
Medicare Section
844 Rush St.
Chicago, IL 60611

Palmetto GBA address for claims and correspondence is:

Palmetto GBA
Railroad Medicare
P. O. Box 10066
Augusta, GA 30999

The Palmetto GBA Railroad Retirement Benefits office is located at:

Palmetto GBA
Railroad Medicare
2743 Perimeter Parkway
Augusta, GA 3090*9*

Carriers should forward claims for services rendered in Canada to:

Railroad Retirement Board
Medicare Section
844 Rush Street
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.

10.1.8 - United Mine Workers of America (UMWA)

(Rev. 1, 10-01-03)

B3-3110.C

The carrier jurisdiction claims of beneficiaries who belong to the UMWA are processed by the UMWA. Carriers who receive claims from such beneficiaries are notified in the query reply of such involvement. Carriers will transfer the claim to:

UMWA Health and Retirement Funds
Box 9224
Van Nuys, CA 91409
ATTN: Medicare Payments

NOTE: The carrier includes the full name and address of the provider of service with all transferred claims, including those received electronically.

10.1.9 - Disposition of Misdirected Claims to the Carrier

(Rev. 1, 10-01-03)

B3-3110

This section applies to misdirected carrier claims that are payable by Medicare carriers and have been sent to the wrong carrier or are payable by the RRB, but have been sent to a carrier other than Palmetto. It does not apply to misdirected claims that are payable by a DMERC, but have mistakenly been sent to the incorrect DMERC. Current processes per the DMERC statement of work should be followed for those claims. It also 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 - Area Carrier/DMERC to Another Area Carrier/DMERC

(Rev. 1, 10-01-03)

B3-3110.E

When a carrier or DMERC receives a claim for services furnished by a physician or supplier serviced by another carrier/DMERC:

Assigned Claims from physicians and other suppliers that must accept assignment - It returns the claim to the sender as unprocessable.

Nonassigned Claims from beneficiaries - It denies unassigned services.

Carriers pay services correctly submitted them.

They use the following messages:

Remittance Advice (RA) (See Chapter 22 for additional information on RAs).

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

New 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 http://www.cms.hhs.gov/."

Medicare Summary Notice (MSN) (See Chapter 21 for additional information on MSNs).

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 - Area Carrier to RRB-Named Carrier

(Rev. 1, 10-01-03)

B3-3110

When a carrier receives a request for Medicare payment (Form CMS-1490S, Form CMS-1500, or Form G-740, the RRB equivalent to Form CMS-1490S) from or pertaining to a qualified RR beneficiary, they return as unprocessable assigned services and deny unassigned services. They pay services correctly submitted to them.

Carriers 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.

New 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."

The HICN of a QRRB, whether or not the beneficiary is also entitled to social security benefits, will be either a 6-digit or 9-digit number with a letter prefix of one, two, or three letters, e.g., A-000000, or MA-000-00-0000.

10.1.9.3 - RRB-Named Carrier to Area Carrier

(Rev. 1, 10-01-03)

When Palmetto GBA, the RRB-named carrier, receives a request for Medicare payment with a suffix number, it returns the claim to the sender and notifies them that the claim must be submitted to the Medicare carrier or DMERC for processing.

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

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)

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).

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.

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.

20 - Provider Election of FI

(Rev. 1, 10-01-03)

A2-2807.A, A3-3600.4, OPT-122

Except as noted below, a provider may elect from among FIs authorized to serve other providers in the provider's area. The provider is informed of the available FIs during the certification or enrollment process. If a provider wishes to elect another FI or is dissatisfied with this arrangement, it can contact the CMS Regional Office. Regional Office contacts are available on the CMS Web site.

Certain types of freestanding or independent providers cannot choose their FI. Freestanding or independent for this purpose refers to the organizational status and management control of the institution; not to whether or not they are located in a separate building.

These are:

- Comprehensive Outpatient Rehabilitation Facilities (CORFs);
- Community Mental Health Centers (CMHCs);
- Outpatient Physical Therapy (OPT) facilities;
- Rehabilitation Agencies (these fall under the umbrella of OPT facilities); and
- End Stage Renal Disease (ESRD) facilities.

These providers must be assigned to the local FI serving the state where the provider is located. This means that the providers can be assigned to the local Blue Cross Plan or to

Mutual of Omaha. In addition, this group of providers will not be able to receive single FI status. Some exceptions have been made for ESRD facilities. The CMS has allowed ESRD facilities to have a single FI.

Freestanding or independent Rural Health Clinics (RHCs) must be assigned to their designated FI. Provider-based RHCs are serviced by the same FI as the parent provider. That is, if the RHC is provider-based to a hospital, then the hospital's FI processes both the hospital's and the RHC's claims.

All Federally Qualified Health Care Centers (FQHCs) are assigned to United Government Services (UGS).See §20.1 for HHAs and hospice FI designations.

All other providers may elect to be served by an intermediary authorized to serve other providers in its areas. Providers receive a form for intermediary preference and associated instructions in their initial certification package sent by the State. Elections are received by the RO. They will usually be approved unless special or temporary limitations have been placed on the elected intermediary's availability, or it is determined that an addition to the elected intermediary's workload at the time would be undesirable. The RO notifies the FI about changes in its list of providers.

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. 1, 10-01-03)

A2-2807.C, PIM Ch10

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 (see 42 CFR 489.18(c) the CMS Regional Office must be notified 45 days prior to the CHOW per instructions contained in Section 3210.5 of the State Operation Manual. If the prospective owner provides a 45-day notice to the CMS/RO, then they will not be automatically assigned the existing provider agreement, thus avoiding the old owner's Medicare liabilities. If the new owner wishes to provide services to Medicare beneficiaries they must request participation in the Medicare program as a new applicant, and will be subject to the survey or certification process. When certified, a new provider agreement with a new provider number will be issued to the new owner. In this situation providers may be eligible to request a change of FI (see §20.4).

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. 1, 10-01-03)

A2-2807.D

NOTE: CMS does deny certain freestanding providers. Refer to §20 for information on becoming a chain facility.

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 - The Process for a Provider to Change an FI

(Rev. 1, 10-01-03)

A2 2808

If an eligible participating provider wishes to change its FI, it must send a written request to their RO at least 120 days (but not more than 180 days) prior to the end of their current fiscal year. The request should be signed by an authorized representative and submitted with an explanation of how the change would contribute to the effective and efficient operation of the Medicare program. The RO where the change is requested will be the coordinating RO for the COI process. The coordinating RO must conduct an investigation on the provider by contacting the current FI. The current FI must submit to the coordinating RO a current FI performance report on the provider. If the FI is not in the coordinating RO's area, then the coordinating RO will notify the appropriate RO of the request and they will contact the FI for the investigation.

The coordinating RO also contacts the requested FI to see if they can take on the additional workload. Requests are usually completed between 30-60 days. Since changes of FI can be costly and disruptive to the Medicare program, the coordinating RO makes a determination based on the reasons given and other pertinent factors, if a change is justified and is consistent with effective and efficient Medicare operations. If the coordinating RO approves the change it becomes effective on the first day following the close of the fiscal year in which the provider gave timely notice. If the approved change results in the provider having facilities in several RO jurisdictions, then the coordinating RO will send each affected RO a notice so that they may prepare tie-in notices for the providers in their region.

If the transfer is denied, the coordinating RO must send the provider a denial letter. The letter must explain why the request was denied. It will also let the provider know that they have the right to appeal the decision. An appeal can be filed by sending a letter to the Director of the Medicare Contractor Management Group at the CO. If the COI request is approved, the CO will notify the provider and the coordinating RO of the decision. The coordinating RO will then implement the transfer.

FIs are prohibited from any actions that involve the solicitation or encouragement of providers to change their FIs.

20.5 - FI Relationships With Providers Serviced by Another FI

(Rev. 1, 10-01-03)

A2.2809

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

(Rev. 1, 10-01-03)

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.

20.5.2 - Communications

(Rev. 1, 10-01-03)

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 an 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. 1, 10-01-03)

SNF-317, RHC-321

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.

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. 1, 10-01-03)

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 to Facility

The carrier may pay the facility in which the service was furnished if there is a contractual arrangement between the facility and the physician or other supplier under which the facility bills for the physician's or other supplier's service. (See §30.2.7.)

F - Payment to Organized Health Care Delivery System

The carrier may pay an organized health care delivery system if there is a contractual arrangement between the organization and the physician or other supplier under which the organization bills for the physician or other supplier's services. Services of independent contractors must be performed on the premises of the health care delivery system. (See §30.2.8.)

G - 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.)

H - 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.)

I - 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.)

J - 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. 1, 10-01-03)

A3-3488.2, B3-3060.11

Absent a court order, Medicare payments due a provider or supplier of services may be sent to a bank (or similar financial institution) for deposit in the provider/physician/supplier's account only if the check is drawn in the name of the provider/physician/supplier and the provider/physician/supplier certifies that this payment arrangement will continue only so long as the following requirements are met:

- The bank is neither providing financing to the provider nor acting on behalf of another party in connection with the provision of such financing; and

- The provider/physician/supplier has sole control of the account, and the bank is subject only to the provider instructions regarding the account. (Thus, if the bank is under a standing order from the provider/physician/supplier to transfer funds from the provider/physician/supplier's account to the account of the financing entity in the same or another bank and the provider/physician/supplier rescinds that order, the bank honors this rescission notwithstanding the fact that the rescission breaches the provider/physician/supplier's agreement with the financing entity.)

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 billing agent for the provider and receives and deposits in the provider/physician/supplier's bank account the provider/physician/supplier's Medicare payments may draw on those funds to pay for its billing services.

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

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 to Facility in Which Services Are Performed - Carrier Claims Only

(Rev. 1, 10-01-03)

B3-3060.2

The carrier may pay Part B benefits for covered physician services furnished in a facility to the facility under assignment or for enrollees that did not execute assignment before death if the facility and the physician have entered into an agreement under which only the facility may bill and receive the fees or the amounts charged for the services furnished, and certain other conditions and limitations described below are met.

The contractual arrangement between the facility and a physician may apply to all services the physician furnishes in the facility, or merely to a particular category of services that is clearly distinguishable from other categories, e.g., services in the outpatient part of the facility by a physician who also collects fees for the services furnished to inpatients. The distinction between the categories must be consistent with proper determination of Part B payment and may not be based on whether the patient has Medicare.

A - Scope of the Term "Facility"

The term "facility" is limited for purposes of this rule to institutions which provide inpatient services (an institution which qualifies as a facility, on this basis, may also bill for services furnished in the facility to outpatients of the facility), i.e., hospitals, critical access hospitals, skilled nursing facilities, nursing homes, the skilled nursing facility or nursing home units of retirement homes, and other institutions of a similar nature. Physician services furnished outside the physical premises of a facility are considered furnished in the facility if they are furnished to an inpatient of the facility or if they represent tests done on specimens obtained from the patient, or interpretations of tests done, while the patient is within the physical premises of the facility. For example, where a hospital takes its patients to the private office of a neurologist for a necessary test, such as encephalography, these services are considered performed in the facility for purposes of honoring a contractual arrangement under which the hospital bills for them.

Physician services furnished outside the physical premises of a facility are also considered furnished in the facility if they are associated with services furnished by the facility (directly, or under arrangement within the meaning of §1861(w) of the Act) and not customarily separately identified by the facility in its charges to private patients.

In some cases a hospital purchases services for its patients from another hospital under arrangement, and such services include a physician component. Where the physician has entered into a valid contractual arrangement with the hospital in which his/her services were rendered permitting the hospital to bill for the services, no additional written authorization is needed. For example, where Hospital A arranges to obtain an EEG interpretation from Hospital B and Hospital B has a valid contractual arrangement with

its neurologist authorizing it to bill for physician services, Hospital A does not need written authorization from the neurologist to bill the program for the cost of these services. It is improper for Hospital B to bill the program for the physician services for which Hospital A has paid.

Under §10.1, carrier jurisdiction for processing claims rendered in a physician's office or other nonprovider facility depends on the actual physical location where the services were rendered.

B - Information Necessary to Permit Payment to Facility

A facility may qualify to receive payment for the services of physicians in the facility by submitting the Form CMS-855R, certifying that it will bill for services only as provided in its written contractual arrangements with them. Carriers must maintain general information in their files as to the nature of the facility, unless this is evident. Form CMS-855R must be completed and submitted to the appropriate carrier each time a physician or other supplier reassigns their benefits to a facility or terminates reassignment.

C - Indirect Contractual Arrangement

A contractual arrangement between a physician and a facility in which the physician performs services may exist indirectly by reason of a contractual arrangement between the physician and some other entity and a contractual arrangement between that entity and the facility. A facility that has an indirect contractual arrangement with a physician is not entitled to bill and receive payment for the physician's services merely on that basis. In order for the facility to bill and receive payment for the physician's services, the facility must also enter into a direct contractual arrangement of the kind described in §30.2.8.1 with the physician, and must certify that it will bill and receive payment for the physician's services only so long as it has this direct arrangement

EXAMPLE 1

A professional corporation enters into a contractual arrangement with a hospital to provide physician emergency room services for the hospital. Under this arrangement the hospital alone bills and receives payment for physician services provided by the corporation and pays the corporation fair market value for the services provided. The corporation in turn employs several physicians to provide the services and, under the terms of their employment, is entitled to receive any fees for their services (other than the portion retained by the hospital under its agreement with the corporation). The combination of the two arrangements (between the hospital and the corporation and the corporation and the physicians) constitutes an indirect contractual arrangement between the hospital and the physicians. For the hospital to bill and receive payment for the emergency room physician services, the hospital must also enter into a direct contractual arrangement with the physicians for this purpose.

In Example 1, the entity that created the indirect contractual arrangement between the facility and the physicians was an entity which would itself be entitled to bill and receive

payment for physician services if it had not entered into the contractual arrangement with the facility for the latter to do so. It is not necessary, however, that this be the case. The indirect contractual arrangement can be created by an entity which is not entitled to bill and receive payment for the physician services, such as, when the physicians providing the services in the hospital's emergency department are independent contractors. In this case, either the independent contractor physician that provided the emergency room service(s) may bill the Medicare program, or the hospital may bill the Medicare program for the service(s) provided by the independent contractor physician under a reassignment.

EXAMPLE 2

The facts are the same as in example 1 except that the professional corporation subcontracts the responsibility for providing the emergency room services to physicians who are independent contractors. Even though the corporation may not itself bill and receive the payments for the physician services, the hospital may do so if it enters into direct contractual arrangements with the physicians for this purpose.

EXAMPLE 3

A hospital contracts with a nonphysician supplier to obtain EEG services. The EEG company administers the EEG to the hospital patient and transmits the reading telephonically to an independent physician to whom it has subcontracted provision of this interpretation. The contract between the hospital and the EEG company and the EEG company and the physician creates an indirect contractual arrangement between the hospital and the physician. However, the hospital may submit Part B claims and receive Part B payment for the physician interpretations only if it also enters into direct contractual arrangements with the physician for this purpose.

30.2.8 - Carrier Payment to Health Care Delivery System - Claims Submitted to Carriers

(Rev. 1, 10-01-03)

B3-3060.3

A carrier may pay Part B benefits for covered physicians, practitioners or suppliers services under assignment or for a deceased beneficiary that did not execute assignment before death to an organization which provides and administers health care services through a health care delivery system, if the organization and the physician enter into a contractual arrangement that allows the health care delivery system to bill and receive payment for services provided by the physician.

A - Meaning of Health Care Delivery System

A health care delivery system is an organization that provides and administers health care to individuals and groups of individuals through an organized health care delivery system.

There are three types of organizations that provide and administer health care through a health care delivery system:

- Clinics;
- University-affiliated medical faculty practice plans; and
- Managed care organizations that provide services through a network of contracting providers, including health care prepayment plans (HCPPs), cost-contracting HMOs, competitive medical plans (CMPs), and Medicare + Choice (M+C) Organizations.

Carriers make reassignment payments to each category of organizations as provided in the specific sections that follow.

Form CMS-855R must be completed and submitted to the appropriate carrier each time a physician or other supplier reassigns their benefits to a health care delivery system or terminates their reassignment. The physician or nonphysician practitioner must be individually enrolled in the Medicare program in order to reassign their benefits.

30.2.8.1 - Definition of Health Care Delivery System

(Rev. 1, 10-01-03)

B3-3060.3.C

For purposes of billing and receiving payment under reassignment as a health care delivery system, a health care delivery system is a clinic. A clinic is a freestanding entity (e.g., a physician, medical group, outpatient dialysis facility, ambulatory surgical center, or imaging center) that provides diagnostic and/or therapeutic health care services on an outpatient basis in quarters which it owns or leases. A clinic may have more than one location. The carrier may make payment to the clinic for services provided on the premises of the clinic by an independent contractor physician as long as the clinic enters into a contractual arrangement with the physician allowing the clinic to bill and receive payment for the physician's services. The health care delivery system exception does not apply, however, when the physician is associated with the clinic as a sole proprietor, partner, or employee (in which case payment may be made to the clinic as a sole proprietorship, partnership, or employer in accordance with §§30.2.8.2 or 30.2.7) or where payment may be made to the clinic under §§30.2.9 - 30.2.11 (purchased tests, purchased interpretations, reciprocal billing, and locum tenens arrangements.

For purposes of this section, independent contractor is intended to apply mainly to physicians. However, independent contractors may also include nonphysician practitioners, such as, certified registered nurse anesthetists (CRNAs), clinical social workers, clinical psychologists, nurse practitioners, or clinical nurse specialists. It would not include a physician's assistant (PA), because payment for their services must be made to their employer. According to §4512 of the Balanced Budget Act of 1997 (BBA) (P.L. 105-33), effective January 1, 1998, PAs may be a Form W-2 employee or Form 1099

independent contractor. CRNAS are not bound by these reassignment rules. They are subject to the provisions in §1833(l)(5)(A) of the Act, which states that payment for CRNA services may be made if the CRNA has an employment or independent contractual arrangement with a qualified health care provider.

Form CMS-855R must be completed and submitted to the appropriate carrier each time a physician or other supplier reassigns their benefits to a clinic or terminates their reassignment. The physician or nonphysician practitioner must be individually enrolled in the Medicare program in order to reassign their benefits.

To determine the effect of an indirect contractual arrangement between a clinic and a physician through another entity, follow the rules in §30.2.7 on the effect of an indirect contractual arrangement between a facility and a physician through another entity.

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,

5. 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 for Purchased Diagnostic Tests - Claims Submitted to Carriers

(Rev. 1, 10-01-03)

B3-3060.4, R1813B3

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 Chapter 12 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, per Chapter 26 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.

- 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.

Refer to Chapter 16 for more information.

30.2.9.1 - Payment to Supplier of Diagnostic Tests for Purchased Interpretations

(Rev. 1, 10-01-03)

B3-3060.5

A person or entity 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 provider identification number and 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.

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

(Rev. 1, 10-01-03)

B3-3060.6

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; 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) 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, and make this record available to the carrier upon request.

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. 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) in block 24k 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. 1, 10-01-03)

B3-3060.7

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; 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) to the carrier upon request.

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, 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) on block 24k 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. 1, 10-01-03)

B3-3060.9

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

Carriers assign a provider identification number (group number) to the medical group, or other entity as a whole. The entity's identification number is entered in block 33. Each physician who performs services for a patient must be identified on Form CMS-1500 in block 24k 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 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 Pathology Claims

Clinics that have been certified to provide outpatient physical therapy or speech 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. 1, 10-01-03)

B3-17000, A3-3005

Institutional providers (those that bill 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.

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. 1, 10-01-03)

B3-3040.4

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, medical nutritional therapists;
- Ambulatory surgical center services;
- Home dialysis supplies and equipment paid under Method II;
- Drugs; and,

- Ambulance services

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

Note that, unlike providers 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.

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. 1, 10-01-03)

B3-3045.1

A - General

An assignment is an agreement between a physician (or other supplier of services) and an enrollee where the enrollee transfers to the physician/supplier his/her right to benefits based on covered services specified on the assigned claim. 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.

In effect, the physician/supplier who accepts assignment 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 request a review and a hearing.

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 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. It may come to a carrier's attention that the physician/supplier has received an excessive amount; inform him/her to refund such amount to the appropriate party. Where there is not definite information as to whom 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, and any excess amount paid by private insurance to it.

A physician/supplier who accepts assignment for some services is not ordinarily precluded from billing the patient for other services. A physician/supplier may attempt to circumvent the Medicare allowed amount limitation by fragmenting his/her bills. A physician/supplier may not accept assignment for some services, and claim payment from the enrollee for other services he/she performed at the same place and on the same occasion. When carriers become aware that a physician/supplier is fragmenting his/her services, they must inform him/her that this practice is unacceptable and that he/she must either accept assignment or bill the enrollee for all services performed at the same place and on the same occasion.

EXCEPTION

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.

B - Rescission of the Assignment

The Medicare allowed amount limitation is a condition of the assignment agreement. It is not affected by a "side agreement" between the parties or between either one and a third party, nor is it affected by any actual or purported misunderstanding of either or both. Once entered into, an assignment cannot be unilaterally rescinded by either party. It may be rescinded only before the carrier has made and sent a notice of the Medicare allowed amount determination. When proper rescission is made and received timely carriers must process the request for payment as an unassigned claim.

The assignment agreement cannot be rescinded after notice of the determination has been sent, but either party may appeal the Medicare allowed amount determination. Thus, a physician who has submitted an assigned claim cannot rescind the assignment by sending the enrollee a notice to this effect or by sending a bill to the enrollee for the full charge

for the services. The fact that the enrollee who receives such a bill pays it in full and submits the bill to the carrier as an unassigned claim does not necessarily constitute an expression of a mutual desire to rescind the assignment agreement.

EXAMPLE

A physician accepted assignment from an enrollee on a bill for $70 and submitted the claim to the carrier. The fee schedule amount was $50, and the carrier paid him/her $40. The physician returned the $40 check with a letter stating that he/she was dissatisfied with the charge, had "cancelled" the assignment, and would collect the $70 from the enrollee directly. The physician's attempted rescission of the assignment is ineffectual because it was communicated after the Medicare allowed amount determination, and because it was unilateral. However, carriers treat the physician's statement as a request for review. In this case the carrier would inform the enrollee of his/her rights (i.e., he/she need pay no more than any unpaid part of the difference between the benefit and the Medicare allowed amount).

EXAMPLE

An ambulance company has a contract with a municipality to furnish specified services to its residents for a fixed price. The municipality agrees to pay the difference between this fee and any lesser amount collected by the ambulance company on assignment from the patient's SMI. If the Medicare allowed amount is less than the stipulated fee, it would be a violation of its assignment agreement for the ambulance company to accept (or try to collect) from the municipality any amount greater than the difference between the SMI benefit and the Medicare allowed amount. The supplier is bound by the Medicare allowed amount limitation under the terms of the assignment regardless of any other agreement it may have with a third party.

C - Effect of the Deductible

A physician/supplier who accepts assignment is bound by the Medicare allowed amount as determined by the carrier with respect to covered services even though no benefit is payable because of the deductible. Thus, if a physician/supplier submits an assigned bill for $40, on which the Medicare allowed amount is $35, and the enrollee has not met any part of the deductible, the physician/supplier is bound by the assignment agreement, even though no Medicare payment can be made. The physician/supplier, therefore, is entitled to collect only the $35 Medicare allowed amount from the patient.

D - Partially Paid Bills

If a physician/supplier accepts assignment of the unpaid portion of a partially paid bill, he/she is bound to accept the Medicare allowed amount as his/her full charge, even though it is found to be equal to or less than the amount already paid. No Medicare benefit is payable. If the approved payment amount is less than the amount already paid, the physician/supplier must refund the difference. However, if a physician/supplier submits an apparently assigned claim that shows that the enrollee **has already paid** the physician/supplier 's charge, there is no assignment. He/she is not bound by the

limitation. Carriers process the claim for payment to the enrollee. They inform the physician/supplier that since the full bill was paid prior to his/her submission of the claim, it could not be assigned.

E - Effect of Time Limitation

Where a physician/supplier accepts an assignment within the time limit for filing, and then delays submittal of the claim until no payment can be made to him/her or to the enrollee, he/she cannot charge the enrollee for the services shown on the bill except for the 20 percent coinsurance and any unmet part of the deductible. (See §70 for a description of the time limitation on filing claims.) To provide a satisfactory approximation of the patient's liability under this principle while avoiding unproductive effort in a situation where payment is precluded, the carrier will assume the deductible has been met and will inform the enrollee and the physician, in cases where the actual charge is $300 or less, that the physician may collect no more than 20 percent of such charge from the enrollee. Where the actual charge is more than $300, the carrier will also assume the deductible has been met, will determine the Medicare allowed amount, and will advise the physician/supplier and enrollee that the patient's liability is 20 percent of such Medicare allowed amount.

F - Nonrendered Service

An allegation that certain services on the assigned claims were not rendered raises the issue of fraud, among other matters, and the instructions in the Medicare Program Integrity Manual apply.

Where the incorrect billing is attributable to error or inadvertence, and this can be determined from a review of in-house records only, the carrier will take prompt corrective action and determine any existing overpayment. Where cases were referred by the RO, the carrier should advise the RO of its findings prior to collecting any existing overpayment. The enrollee or physician/supplier or both may request an informal review and hearing on the carrier's findings as to services rendered or on the Medicare allowed amount determination. Both parties are bound by the carrier's determination on these issues. However, where the carrier determines that the incorrect billing is **not** attributable to either error or inadvertence, the carrier must refer the matter to the RO without requesting refund of any determined overpayment. At no time should the carrier contact the physician/supplier or provider of services in order to resolve the issue.

G - Noncovered Services

Noncovered services include tests, visits, and procedures that are not reasonable or necessary by accepted medical standards, i.e., the services are found to be inappropriate or in excess of those required for diagnosis or treatment of the enrollee's condition and statutory exclusions. The physician (or supplier) is not precluded by the assignment from charging the patient for such noncovered services, unless waiver of the patient's liability under §1879 of the act is applicable. This section of the act provides that the patient is not liable for payment for services that are determined not reasonable or necessary where

he/she did not know (and could not reasonably have known) that the services were not covered. Where it is established that the physician (or supplier) also did not know (and could not reasonably have known) that the services were not covered, Medicare will accept liability. However, when the beneficiary did not have such knowledge, but the physician (or supplier) knew or could have reasonably been expected to know of the noncoverage of items or services, the liability for the charges for the denied items or services rests with the physician. See §§60 for instructions regarding the required notices to the beneficiary for noncovered services.

In addition, where a physician has been found at fault in causing an overpayment for excessive or inappropriate services, discovered in or after the fourth calendar year after the year in which the original payment determination was made, he/she is prohibited from charging the payment or other person if the patient was with fault.

Although the physician makes no commitment not to charge for such noncovered services, such charges are likely to be improper except in certain unusual circumstances (e.g., unnecessary services were furnished only because of the insistent request of an overanxious patient or his/her relative, after he/she had been clearly informed that such services were not covered under medical insurance because they were not necessary, and would have to be paid for out of the patient's or relative's own pocket). Ordinarily, such improper charges are inconsistent with medical ethics. Where an enrollee complains because a physician is billing him/her for such improper charges (or it otherwise comes to the carrier's attention) the carrier will consider whether the enrollee is protected from liability under §1879 of the Act. If the physician (or supplier) is being held liable for the charges for the noncovered services and the physician (or supplier) requests and receives payment from the beneficiary for payment of the noncovered charges, the Medicare program will indemnify the beneficiary less the applicable deductible and coinsurance amounts. Any such indemnification payments will be considered overpayments to the physician (or supplier). In addition, the carrier may, with the enrollee's authorization, consider referral of the case to the medical society or State licensing board. Alternatively, it may be proposed to the enrollee that he/she present his/her complaint to the local medical society personally.

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

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. 1, 10-01-03)

B3-3040

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 claims 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. 1, 10-01-03)

B3-17001

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 provider (including physicians and suppliers) an amount, which the provider (including physicians and suppliers) 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 provider (including physicians and suppliers) to submit a single claim for the Medicare and private plan benefits to the private health benefits plan. The provider (including physicians and suppliers) 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 providers (including physicians and suppliers) 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 provider (including physicians and suppliers) 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 provider (including physicians and suppliers) 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 provider (including physicians and suppliers) 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 provider (including physicians and suppliers) 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 provider (including physicians and suppliers) 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 or carbon copy 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 beneficiaries.

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 provider (including physicians and suppliers) 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 Form CMS-855 form for new enrollees. Carriers must furnish a special 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 tier 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 reprinting. 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. 1, 10-01-03)

B3-17001.1, PM-B-02-048

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

For the annual participation enrollment CMS will furnish carriers with a participation announcement and fact sheet to send physicians and suppliers. 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.

The Medicare Physician Fee Schedule Database will be transmitted electronically to carriers by CMS on or about October 18 of each year. Carriers mail the annual participation materials to 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.

Carriers must send an annual participation enrollment announcement, fact sheet, and, unless otherwise specified, a complete locality disclosure report to physicians and suppliers eligible to enroll. They include a blank participation agreement in packages sent to the following non-participating physicians and suppliers:

- All physician specialties included in the 01-99 specialty range; (An entire locality fee schedule report need not be furnished to chiropractors. At a minimum, furnish chiropractors with fee data for procedure codes for which they may receive payment.)
- 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) (Carriers may limit their disclosure for Mammography Screening Centers to procedure codes for which they may receive payment.)
- Independent Diagnostic Testing Facilities (specialty 47);
- Audiologists (specialty 64); and
- Independently Billing Psychologists (specialty 62).

For the following suppliers carriers send an annual participation announcement and a fact sheet. They include a blank participation agreement for 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 fee disclosure reports and send them to specialty 49, 59 and supplier specialties other than 51-58 with their participation enrollment packages, 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.

C - Minimum Requirements for Disclosure Reports

Carriers must use valid CPT and HCPCS codes for creating disclosure reports for physician fee schedule services. They provide complete locality data for all procedure codes with a status indicator of A, T, D, H, and R (for which CMS has established the RUVs) on the Medicare Physician Fee Schedule Database. They include limiting charges 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 legend “"All CPT codes and descriptors copyright (appropriate year) American Medical Association"#” (on each report page).

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

The following two statements must be included on the fee disclosure reports:

> “All Current Procedural Terminology (CPT) codes and descriptors are copyrighted by the American Medical Association.” (on each report page).
>
> “These amounts apply when service is performed in a facility setting.”

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 nonfacility RVUs).

In addition to sending disclosure reports in the participation enrollment package, the carrier may, at its discretion, and within the constraints of your authorized budget, load the fees on its Internet Web site or electronic bulletin board if it has either. If it chooses to use descriptors, it must use the short descriptors. The CMS has signed an agreement with the American Medical Association regarding use of CPT on Medicare Contractor Web sites, bulletin boards, and other electronic communications.

The carrier mails participation enrollment/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.

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.

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 the 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. Physician assistants (specialty 97);

- Certified registered nurse anesthetists (CRNAs) (specialty 43);
- Certified nurse midwives (specialty 42);
- Clinical nurse specialists (specialty 89);
- Nurse practitioners (specialty 50);;
- Registered dietitians/nutritionists (specialty 71);
- Clinical Psychologists (specialty 68);
- Anesthesiologist assistants (AAs) (specialty 32); and
- Clinical Social Workers (specialty 80).

Carriers do not send a participation enrollment package to these practitioners.

NOTE: The provider type Mass Immunization Biller 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. These benefits include:

- No 5 percent reduction in their Medicare approved amount.
- "Beneficiaries with Medigap (private supplemental insurance) may assign the payment on the supplemental claim. Carriers will forward the necessary data, thereby relieving the provider of having to file a second claim."
- Listing in the Medicare Participation Physicians/Suppliers Directory (MEDPARD). (**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.)

NOTE: Although these practitioners do not have to sign participation agreements, carriers include them in the annual MEDPARD as participating. Carriers also include rural health clinics in the annual MEDPARD as participating.

Carriers may create and send 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, http://www.cms.hhs.gov/

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 CPT codes and descriptors copyright (appropriate year) 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 must print all fee schedules on 8-1/2 by 11-inch paper. They use 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.

Carriers may provide the disclosure report in hardcopy, disk or electronic form, depending on cost considerations and arrangements you make with providers. They may not require providers to accept a medium other than paper if they do not prefer an alternative medium.

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 - MEDPARDS

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.

J - 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 announcement, fact sheet, blank participation agreements and disclosure reports;
- Furnish yearly physician fee schedule amounts to CMS for local and 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 for physician services;
- 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 by February of each year. (Separate instructions will be released for furnishing this information.)

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_____

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0373. The time required to complete this information collection is estimated 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.

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 CMS 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. 1, 10-01-03)

A3-3008.4

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 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. 1, 10-01-03)

A3-3302.1, A3-3602.4

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-92), 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 (FL 85), 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-92 and Electronic Billing (Part A and Part B)

(Rev. 1, 10-01-03)

A3-3302.2

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. 1, 10-01-03)

B3-3057

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 or speech therapy 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. 1, 10-01-03)

A3-3603

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.

FIs must ensure that providers adhere to these requirements.

50.2.1 - Inpatient Billing From Hospitals and SNFs

(Rev. 1, 10-01-03)

A3-3603, R1882A3, R1892A3

Inpatient services in TEFRA hospitals (i.e., psychiatric hospitals or units, 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.

Providers will submit a bill to the FI when a beneficiary in a SNF ceases to need active care (occurrence code 22), or a beneficiary in one of these hospitals ceases to need hospital level 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. No-payment bills should be submitted until the beneficiary is discharged.

Inpatient acute-care PPS hospitals, inpatient rehabilitation facilities (IRFs), and long term care hospitals (LTCHs) 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.

The LTCHs 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, inpatient rehabilitation facility, and a long-term care hospital 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 of one of the following:
    - 01 - Discharged to home or self care;
    - 02 - Discharged/transferred to another short-term general hospital;
    - 03 - Discharged/transferred to SNF;
    - 04 - Discharged/transferred to an ICF;
    - 05 - Discharged/transferred to another type of institution (including distinct part), or referred for outpatient services to another institution;
    - 06 - Discharged/transferred to home under care of an organized home health service organization;
    - 07 – Left against medical advice;
    - 08 - Discharged/transferred to home under care of a home IV drug therapy provider;
    - 20 - Expired (or did not recover - Religious Non-Medical Healthcare Institution patient);
    - 43 - Discharged/transferred to a Federal hospital (effective for discharges on and after October 1, 2003);
    - 50 - Hospice - home
    - 51 - Hospice - medical facility
    - 61 - Discharged/transferred within this institution to a hospital-based Medicare approved swing bed.

- 62 - Discharged/transferred to an inpatient rehabilitation facility including distinct part units of a hospital
- 63 - Discharged/transferred to long term care hospitals
- 64 - Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare
- 65 - Discharged/transferred to a psychiatric hospital or psychiatric part unit of a hospital (effective April 1, 2004)
- 71 - Discharged/transferred/referred to another institution for outpatient services as specified by the discharge plan of care (deleted October 1, 2003)
- 72 - Discharged/transferred/referred to this institution for outpatient services as specified by the discharge plan of care (deleted October 1, 2003)

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.

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 for Outpatient and Services to FIs

(Rev. 1, 10-01-03)

Repetitive Part B services to a single individual from providers that bill FIs may be billed monthly (or at the conclusion of treatment). These instructions also apply to hospice services billed under Part A. This reduces CMS processing costs for relatively small claims and in instances where bills are held for monthly review. Examples of repetitive Part B services with applicable revenue codes include:

Type of Service	Revenue Code(s)
DME Rental	0290 - 0299
Therapeutic Radiology	0330 - 0339
Therapeutic Nuclear Medicine	0342
Respiratory Therapy	0410 - 0419
Physical Therapy	0420 - 0429
Occupational Therapy	0430 - 0439
Speech Pathology	0440 - 0449
Home Health Visits	0550 - 0559
Kidney Dialysis Treatments	0820 - 0859
Cardiac Rehabilitation Services	0482, 0943
Psychological Services	0910 - 0919 (in a psychiatric facility)

This does not apply to Home Health Services. See Chapter 10 for requirements for HHAs.

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 may be submitted for the entire month if the provider uses an occurrence span code 74 to encompass the in-patient stay, day of outpatient surgery, or outpatient hospital services subject to OPPS. CWF and shared systems must read occurrence span 74 and recognize that the beneficiary cannot receive outpatient services while an inpatient, and consequently is on leave of absence from repetitive services. This permits submitting a single bill for the month and simplifies FI review of these bills. This is in addition to the bill for the inpatient stay or outpatient surgery.

Other one-time Part B services may be billed upon completion of the service.

Bills for outpatient hospital services subject to OPPS must contain on a single bill all services provided on same day except claims containing condition codes 20, 21, or G0 (zero) or kidney dialysis services, which are billed on a 72X bill type. If an individual OPPS service is provided on the same day as an OPPS repetitive service, the individual OPPS service must be billed on the OPPS monthly repetitive claim. 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 must 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-OPPS services furnished on a day other than the day of surgery must 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
- Modification of duplicate screens to detect bills that meet duplicate criteria except for billing period, but which fall in the same 30 day period.

FIs should educate providers that bill improperly. They must:

- 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. 1, 10-01-03)

A3-3603.1

When a patient remains an inpatient of a SNF, TEFRA hospital or unit, swing-bed, or hospice for over 30 days, these providers may 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 rejected 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 system for an adjudicated claim. If the prior bill is not in the finalized claims history, they reject the incoming bill with an error message requesting the prior bill be submitted first, if not

already submitted, and the rejected bill only be resubmitted after the provider receives notice of the adjudication of the prior bill. A typical error message 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.

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.

60 - Provider Billing of Noncovered Charges

(Rev. 1, 10-01-03)

Note: Instructions for the following are in development.

60.1 - General Information on Noncovered Charges

(Rev. 1, 10-01-03)

60.2 - Noncovered Charges on Inpatient Bills

(Rev. 1, 10-01-03)

60.3 - Noncovered Charges on Demand Bills

(Rev. 1, 10-01-03)

60.4 - Noncovered Charges on Outpatient Bills

60.5- Intermediary Processing of No-Payment Bills

(Rev. 1, 10-01-03)

A3-3624

A - Nonpayment Codes

Intermediaries use nonpayment codes in inpatient CWF records where payment is not made. (Inpatient bills where partial payment is made do not require nonpayment codes.) These codes alert CMS to bypass edits in CWF processing that are not appropriate in

nonpayment cases. The intermediary enters the appropriate code in field 51 of the CWF record if the nonpayment situation applies to all services covered by the bill. 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 bill, it adjusts the bill 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 when benefits and/or lifetime reserve days are exhausted, or when the beneficiary elects not to use them.

2 - Nonpayment Code R

The intermediary uses code R in the following instances when there is technical liability but utilization is charged:

- It denies all SNF inpatient services for other than medical necessity or custodial care, including a provider's failure to submit medical documentation;
- Time limitation for filing expired before billing, and provider is at fault;
- Provider failed to submit needed information; and
- Patient refused to request benefits.

3 - No Payment Situations Not Requiring Nonpayment Code.

- 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, other governmental entity or liability insurance paid for all covered services.
- Services provided to HMO enrollee for which the HMO has jurisdiction for payment. This is option code B or C in R trailer.

4 - Use of Nonpayment Code N in Cases Where Provider Is Liable.

(All charges are shown as noncovered. Utilization is not charged.) Section 4096 of the Omnibus Budget Reconciliation Act (OBRA) of 1987 states that a beneficiary is not responsible for payment of the deductible, coinsurance or the remaining cost of services or items 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.

5 - Use of Nonpayment Code N in Cases Where Provider Is Not Liable.

The intermediary uses code N in the following instances when neither utilization nor cost report days are reported:

- 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 because of days used before admission. (See Medicare Benefit Policy Manual, Chapter 4.)
- All services after active care ended in a psychiatric hospital.
- All services after the date a covered level of care ended (general hospital or SNF).
- MSP cost avoidance denials. (See Medicare Secondary Payer Manuals.)

70 -Time Limitations for Filing Provider Claims

(Rev. 1, 10-01-03)

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. 1, 10-01-03)

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

The prescribed electronic format for Medicare institutional claims was defined by 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. 1, 10-01-03)

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-92, 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. 1, 10-01-03)

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.)

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-92) 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.

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 Timely Filing and Resulting Actions

(Rev. 1, 10-01-03)

Medicare determines a claim is filed timely only through the comparison of the date the services were furnished (line item date or claim statement "from" date) to the receipt date applied to the claim when it is accepted for adjudication. If the span between these two dates exceeds the time limitation defined in §70.1 above, the claim is not received timely. The contractor shall reject claims not received timely. Where the beneficiary request for payment was filed timely (or would have been filed the request timely had the provider taken action to obtain a request from the patient whom the provider knew or had reason to believe might be a beneficiary) but the provider is responsible for not filing a timely claim, the provider may not charge the beneficiary for the services except for such deductible and/or coinsurance amounts as would have been appropriate if Medicare payment had been made. In appropriate cases, such claims should be processed because of the spell-of-illness implications and/or in order to record the days, visits, cash and blood deductibles. The beneficiary is charged utilization days, if applicable for the type of services received.

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

This same 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. 1, 10-01-03)

- 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.

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. 1, 10-01-03)

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.

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

(Rev. 1, 10-01-03)

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

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.

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. 1, 10-01-03)

A3-3600.1-Item 7

The receipt date is the date the carrier or FI receives a claim on which the data are sufficiently complete to qualify as a claim. The receipt date is used to calculate interest payments when due for clean claims, to report statistical data on claims to CMS, such as in workload reports, and to determine if a claim was received timely.

Paper claims received by 5:00 p.m. on a business day, or by closing time if the carrier or FI 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 carrier or FI does not open the envelopes in which the claims are received or does not enter the data into the claims processing system until a later date. Paper claims received after 5:00 p.m. or the carrier or FI's close of business between 4:00 p.m. and 5:00 p.m. may be considered as received on the next business day.

Paper claims are considered received if delivered to the carrier or FI's place of business by the U.S. Postal Service, picked up from a P.O. box(es), or otherwise delivered to the carrier or FI's place of business by its normal close of business time. If the carrier or FI uses a P.O. box for receipt of mailed claims, it must have its mail picked up from its box(es) at least once per business day unless precluded on a particular day by the emergency closing of its office or its postal box site.

As electronic claim tapes and diskettes submitted by providers or their agents are also subject to manual delivery, rather than direct electronic transmission, the paper claim receipt date establishment rule also applies to such tapes and diskettes.

Electronic claims transmitted to a FI, or to a clearinghouse with which the FI contracts as its representative for the receipt of its claims, by 5:00 p.m. in the contractor 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 FI does not upload or process the data until a later date.

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 carrier or FI 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 any claim.

The following exception applies to the FI establishment of receipt date. Where its system or hours of operation permit, the FI may, at its option, classify a paper or electronic claim received between 5:00 p.m. (or its closing time between 4:00 p.m. and 5:00 p.m.) 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 its office closes early in an isolated situation due to an emergency, its cutoff time for establishment of a receipt date may never be earlier than 4:00 p.m.

A carrier or FI may not make system changes, extend its hours of operation, or incur significant additional costs solely to begin to accommodate late receipts if not already equipped to do so.

The cutoff time for paper claims may not exceed the cutoff time for electronic claims. A number of carriers or FIs have reported that a later electronic cutoff time has been an incentive for provider use of electronic filing. 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. 1, 10-01-03)

A3-3600.1A.1, B2-5240.11.C

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.

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.

For purposes of the payment floors and ceilings:

An "electronic claim" is one that is submitted via central processing unit (CPU) to CPU transmission, tape, diskette, direct data entry, direct wire, dial in telephone, digital fax, or personal computer upload or download. The term "digital fax" refers to a claim that the FI receives into its processing system via FAX but does not print out. Rather, the fax is encoded while still in electronic form (generally by an optical code reader (OCR)), and electronically entered into the carrier or FI's claims processing system, eliminating manual data entry.

Beginning January 1, 1996, claims submitted via digital FAX/OCR are not counted or paid as EMC. Beginning October 1, 1998, claims received via diskette, and touch-tone phone are not longer counted or paid as EMC.

A "paper claim" is submitted and received on paper, including fax print-outs. This also includes claims the carrier or FI received on paper and read electronically with OCR technology.

80.2.1.2 - Payment Floor Standards

(Rev. 1, 10-01-03)

A3-3600.1, HO-401.B, B2-5240.11.D

Carriers or FIs do not pay, issue, mail, or otherwise pay for any claim it receives from providers within the waiting period as indicated below. The length of the waiting period is determined by the date a claim is received. The carrier or FI starts its count on the day after the day of receipt. For example, a paper claim received October 1, 1999, can be paid on or after October 28, 1999. An electronic claim received November 1, 1993, can be paid on or after November 15, 1999. See §80.2.1.1 for the definition of EMC and paper claims.

Claim Receipt Date	Waiting Period (Days)
01-01-93 through 09-30-93	14 for EMC and
	26 for paper claims
10-01-93 and later	13 for EMC and
	26 for paper claims

NOTE: No-payment claims are not subject to the payment floor standards. Also RAPs submitted by Home Health Agencies are not considered claims. Payment for RAPs is not subject to payment floor standards.

80.2.2 - Interest Payment on Clean Non-PIP Claims Not Paid Timely

(Rev. 1, 10-01-03)

A3-3600.1 Item 5, HO-401C

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.

Interest must be paid on clean non-PIP claims if payment is not made within the applicable number of calendar 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;
- Claims on which no payment is due;

- Full denials;
- Claims for which the provider is receiving PIP; or
- HH PPS RAPs

However, 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.

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 that 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	November 28, 2001	November 15, 2001
Payment Made	December 4, 2001	December 4, 2001
Interest Begins	December 2, 2001	December 2, 2001
Days for Which Interest is Due	2	2
Amount of Payment	$100	$100
Interest Rate	5.625%	5.625%

See §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 2 divided by 365 = $.0308 or $.03 when rounded to the nearest penny.
>
> For the clean electronic claim - $100 X .05625 X 2 divided by 365 = $.0308 or $.03 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.

80.2.2.1 - Determining and Paying Interest

(Rev. 1, 10-01-03)

The carrier or FI must pay interest on clean, non-PIP (FIs) claims for which it does not make payment within 30 calendar days beginning on the day after the receipt date. It will select claims for interest based upon:

- Reimbursement amount is greater than zero.
- Processing time exceeds 30 days (Julian payment date minus Julian receipt date equals more than 30).

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 carrier or FI applies interest to the payment after all deductions (e.g., deductible, coinsurance, and MSP). Interest is rounded to the nearest penny.

A - Reporting Interest Payment on Remittance Record

When interest payments are applicable, i.e., days after April 1, 1987, the carrier or FI indicates for the individual claims on its remittance record the amount of interest.

B - Payment Made to Beneficiary

If payment is made directly to the beneficiary on a clean claim for which the carrier or FI did not make payment within the applicable number of days (as described in subsection A.1.) the carrier or FI must apply interest. It adds the following messages on any beneficiary notice that it prepares:

> 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. 1, 10-01-03)

A3-3605.1, B3-3005.1

The following definitions apply to §80.3.2. For carriers the requirements apply to Part B assigned claims. For unassigned claims submitted by beneficiaries (Form CMS-1490S), that are incomplete or contain invalid information, carriers suspend and develop the claim. If corrections are not received on such unassigned claims within the suspense period, or if corrections are inaccurate, carriers deny the claim and afford appeal rights

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 RTPed 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 (RTPs)).

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. 1, 10-01-03)

A3-3605.2, B3-3005.2B

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 RTPed. The carrier or FI should 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, RTP the claim to either the supplier or provider of service.
- If a claim must be "returned as unprocessable" or RTP'd 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 RTPed 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" 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.

- If a beneficiary submits a claim with incomplete or invalid information, the carrier or FI suspends and develops the claim. If corrections are not received within the suspense period, or if corrections are inaccurate, then the carrier or FI denies the claim and affords appeal rights.

NOTE: Telephone inquiries are encouraged.

- The carrier or FI will not return an unprocessable claim if the appropriate information for both "required" and "conditional" data element requirements is missing or inaccurate but can be supplied through internal files.

- 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 five 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 list some exceptions when a claim may not be "returned as unprocessable" for incomplete or invalid information.

Carriers 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. 1, 10-01-03)

B3-3005.3, A3-3605.3

The matrix (See Exhibit 1 for carriers and Exhibit 2 for FIs) specifies data elements, which are required and conditional for carrier claims and required, not required, and conditional for FI claims. These standard data elements are minimal requirements for processing a carrier claim. A crosswalk is present to relate Form CMS-1500 items (hardcopy) to fields/records in the NSF 3.01 (electronic) and the Accredited Standards

Committee (ASC) X12N 837 Professional Version 4010X098 implementation guide for use when HIPAA is implemented.

The matrix does not specify item or field/record content and size. For carriers, refer to the printing specifications (hardcopy) and the electronic billing instructions (NSF and 837) on the CMS Web site to build these additional edits. For FIs, refer to §80.3.2.1.1 and the electronic billing instructions (UB-92 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 carrier or FI returns the unprocessable claim to the supplier or provider of service.

Carriers and 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

See Business Requirements at http://www.cms.hhs.gov/manuals/pm_trans/R47CP.pdf

(Rev. 47, 12-19-03)

B3-3005.4

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. They use remark code MA 52 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 11b, 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 MA52 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).

Carriers must return a claim as unprocessable to a provider of service or supplier and use the indicated remark codes 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 use the following:

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 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 if the HCPCS is missing, or M51 for an invalid/obsolete HCPCS.)

Note: Level 3 HCPCS will be going away with HIPAA.

8. If a claim lacks a charge for each listed service. (Remark code M79.)

9. If a claim does not indicate at least one day or unit in item 24G (Note: To avoid returning the claim as "unprocessable" when the information in this item is missing, the FI 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 MA82.)

    AND EITHER

    b. A valid PIN (or NPI when effective) number or, for DMERC claims, a valid National Supplier Clearinghouse number for the performing provider of service or supplier who is not a member of a group practice. (Remark code MA82 or M57 if another provider is involved.)

    OR

    c. A valid group PIN (or NPI when effective) number or, for DMERC claims, a valid National Supplier Clearinghouse number for performing providers of service or suppliers who are members of a group practice. (Remark code MA112.)

80.3.2.1.2 - Conditional Data Element Requirements for Carriers and DMERCs

(Rev. 1, 10-01-03)

B3-3500.4, R1813B3

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. A crosswalk between Form CMS-1500 items and records and fields on the NSF can be found in Exhibit 1.

NOTE: Claims are not returned as unprocessable if the (PIN) Provider Identification Number is at least eight digits in length, and valid.

Carriers must return a claim as unprocessable to the supplier/provider of service:

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 UPIN (or NPI when effective) is not present in item 17 or 17A. (Remark code MA82 is used.)

b. If a physician extender or other limited licensed practitioner refers a patient for consultative services, but the name and/or UPIN (or NPI when effective) of the supervising physician is not entered in items 17 or 17A. (Remark code MA102 is used.)

c. .For diagnostic tests subject to purchase price limitations:

    1. If a "YES" or "NO" is not indicated in item 20. (Remark code M12 is used.)

    2. If the "YES" box is checked in item 20 and the 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, and PIN are

not entered in item 32 when billing for purchased diagnostic tests. (Remark code MA111 is 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 is used.)

e. If modifiers "QB" and "QU" 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 performing physician, physician assistant, nurse practitioner, clinical nurse specialist, supplier/or other practitioner is a member of a group practice and does not enter his or her PIN (or NPI when effective) in item 24K and the group practice's PIN (or NPI when effective) in item 33. (Remark code MA112 is used.)

g. If a primary insurer to Medicare is indicated in item 11, but items 4, 6, and 7 are incomplete. (Remark code MA64, MA85, MA86, MA87, MA88, MA89, or MA92 as appropriate for the missing piece(s) of data is 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 MA85 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, or M78 if the modifier is missing or incorrect is used.)

j. If a date of service extends more than one 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.

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 in item 32.

80.3.2.1.3 - Carrier Specific Requirements for Certain Specialties/Services

(Rev.47, 12-19-03)

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 (or NPI when effective) number is not entered in item 33 or their personal PIN (or NPI number when effective) is not entered in item 24K. (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 the attending physician's PIN (or NPI when effective) is not entered in item 24K. (Remark code MA112 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 effective) is not present in item 19. (Remark code MA104 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 and/or UPIN (or NPI when effective) is not present in items 17 or 17A. (Remark code M33 or MA102 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 and/or UPIN (or NPI when effective) is not present in items 17 or 17A. (Remark code M33 or MA102 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.

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 and/or UPIN (or NPI when effective) is not present in items 17 or 17A. (Remark code MA102 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 effective) are not entered in items 17 or 17A. (Remark code MA102 is used.)

m. For radiology and pathology claims for hospital inpatients, if the referring/ordering physician, physician assistant, nurse practitioner, clinical nurse specialist's name, and/or UPIN (or NPI when effective) if appropriate are not entered in items 17 or 17A. (Remark code MA102 is used.)

n. For outpatient services provided by a qualified, independent physical, or occupational therapist:

1. If the UPIN (or NPI when effective) of the attending physician is not present in item 19. (Remark code MA104 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 MA104 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 (or NPI when effective) where the laboratory services were performed in item 32, 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 MA51 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. (Remark code MA50 is used.)

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.)

80.3.2.2 - FI Consistency Edits

(Rev. 1, 10-01-03)

A3-3606

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 nonhospital services:

2 - Skilled Nursing

3 - Home Health

4 - Christian Science (Hospital)

5 - Christian Science (Extended Care)

7 - Clinic (see special coding for second digit below)

8 - Special Facility, 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 - 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

Second Digit - Classification (first digit is 7):

1 - Rural Health

2 - Freestanding Renal Dialysis Center

3 - Independent or Provider-Based Federally Qualified Health Centers

4 - Other Rehabilitation Facility (ORF) or Community Mental Health Center (CMHC)

5 - Comprehensive Rehabilitation Facility (CORF)

Second Digit - Classification (first digit is "8"):

1 - Hospice (Nonhospital-based)

2 - Hospice (Hospital-based)

3 - Hospital Outpatient (ASC Procedure)

Third Digit - Frequency:

0 - No payment

1 - Full billing (payment)

2 - First interim

3 - Continuing interim

4 - Final interim

5 - Late charge

7 - Correction

8 - Void/Cancel

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, 41X, or 51X.

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.

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, 21X, 33X, 41X, 51X, or 82X.

d. Cannot be later than the “From” portion of Item 6.

FL 19. Type of Admission

a. One numeric position.

b. Required only if the type of bill is 11X or 41X.

c. Valid codes are:

1 - Emergency

2 - Urgent

3 - Elective

9 - Information unavailable

FL 20. Source of Admission.

a. One numeric position.

b. Required if the type of bill is 11X, 13X, 41X, or 83X.

c. Valid codes are:

1 - Physician referral

2 - Clinic referral

3 - HMO referral

4 - Transfer from a hospital

5 - Transfer from a SNF

6 - Transfer from another health care facility

7 - Emergency room

8 - Court/Law enforcement

9 - Information not available

FL 22. Patient Status.

a. Two numeric positions.

b. Present only on Part A bills, bill types 11X, 13X, 18X, 21X, 32X, 33X, 41X, 51X, 81X, or 82X, and Part B bills, bill types 13X, 83X, and 85X.

c. Valid codes for hospital, SNFs and RNHCIs are:

01 - Discharged to home/self care (routine charge)

02 - Discharged/transferred to other short-term general hospital

03 - Discharged/transferred to SNF

04 - Discharged/transferred to ICF

05 - Discharged/transferred to another type of institution (including distinct parts)

06 - Discharged/transferred to home care of organized home health service organization

07 - Left against medical advice

08 - Discharged/transferred to home under care of a home IV drug therapy provider

09 - Admitted as an inpatient to this hospital (only valid for outpatient hospital bills for services prior to the third day before admission)

20 - Expired (did not recover - Christian Science patient)

30 - Still patient

43 - Discharged/transferred to a Federal hospital (effective for discharges on and after October 1, 2003)

50 - Hospice - home

51 - Hospice - medical facility

61 - Discharged/transferred within this institution to a hospital-based Medicare approved swing bed

62 - Discharged/transferred to an inpatient rehabilitation facility including distinct part units of a hospital

63 - Discharged/transferred to long-term care hospitals

64 - Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare

65 - Discharged/transferred to a psychiatric hospital or psychiatric part unit of a hospital (effective April 1, 2004)

71 - Discharged/transferred/referred to another institution for outpatient services as specified by the discharge plan of care (deleted October 1, 2003)

72 - Discharged/transferred/referred to this institution for outpatient services as specified by the discharge plan of care (deleted October 1, 2003)

d. Valid codes for hospice (81X or 82X) are:

01 - Discharged (left this hospice)

30 - Still patient (remains a patient)

40 - Expired at home

41 - Expired in a medical facility such as a hospital, SNF, ICF, or freestanding hospice

42 - Expired - place unknown

50 - Hospice - home

51 - Hospice - medical facility

61 - Discharged/transferred within this institution to a hospital-based Medicare approved swing bed.

62 - Discharged/transferred to an inpatient rehabilitation facility including distinct part units of a hospital

63 - Discharged/transferred to long-term care **hospitals**

64 - Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare

FL 23. Medical Record Number

a. If provided by the hospital, must be recorded for the PRO.

b. Must be left justified in CWF record for PRO.

FLs 24, 25, 26, 27, 28, 29, and 30. Condition Codes.

a. Each code is two numeric digits.

b. Valid codes for Medicare are:

02, 04, 05, 06, 07, 08, 09, 10, 11, 15, 16, 20, 21, 26, 27, 28, 29, 36, 37, 38, 39, 40, 41, 55, 56, 57, 60, 61, 62, 63, 64, 65, 66, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, A5-A9, C1-C7, D0-D9, E0, EY, H0

c. If code 07 is entered, type of bill must not be hospice 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 01-99 and A0-Z9.

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 first digit in FL 4 must be “3” and the second digit “2” or “3.”

g. If code 28 is entered, the first digit in FL 4 must be a “7” and the second digit “4” or “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.
- Cannot be more than three 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 34 is entered, then the type of bill must be 51X.

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:

70	74	77	M0
71	75	78	M1
72	76	79	

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, 74X, or 75X.

h. If code 75 is entered, the first digit of FL 4 must be “1” or “4” and the second digit must be “1.”

i. If code 76 is entered, occurrence code 31 or 32 must be present (inpatient only).

j. If code 76, 77, 79 or M1 is present, the bill type must be 11X, 13X, 14X, 18X, 21X, 34X, 41X, 71X, 72X, 74X, 75X, 81X, 82X, or 85X.

k. Code M0 must be present only if FLs 24-30 contains code C3.

l. 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.

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:

04-06	37-44	68	A1-A3	D3
08-19	46-53	70-72	B1-B3	
31	56-60	75-77	C1-C3	

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. Five numeric positions.

b. Must be listed in ascending numeric sequence except for the final entry, which must be "00001."

c. There must be a revenue code adjacent to each entry in FL 47.

d. For bill type 13X or 83X, the following revenue codes require a 5-position HCPCS code:

0274, 030X, 031X, 032X, 034X, 035X, 040X, 046X, 0471, 0481, 0482, 061X, 0730, 0732, or 074X.

e. For bill type 32X, 33X, or 34X, the following revenue codes require a 5-position HCPCS code:

0271, 0272, 0273, 0274, 0601, 0602, 0603, or 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 44. HCPCS Codes.

For bill type 13X or 83X, the HCPCS codes below must be reported with the specific revenue code shown. These revenue codes can also be reported with other HCPCS codes.

046X	94010, 94060, 94070, 94150, 94160, 94200, 94240, 94250, 94260, 94350, 94360, 94370, 94375, 94620
0471	92504, 92511, 92541, 92542, 92543, 92544, 92545, 92551, 92552, 92553, 92555, 92556, 92557, 92563, 92567, 92568, 92569, 92575, 92584, 92585
0480	93307, 93308, 93320
0482	93017
0636	Revenue code 0636 relates to the HCPCS code for drugs requiring detailed coding.
0730	93005, 93024, 93041, 93202, 93208, 93221
0731	93225, 93024, 93041, 93202, 93208, 93221

0732	93012
074X	95819
075X	91010, 91011, 91012, 91020, 91030, 91055
0921	93721, 93731, 93732, 93733, 93734, 93735, 93736
0922	95860, 95861, 95863, 95864, 95867, 95868, 95869, 95872, 95900, 95904, 95925, 95935, 95937

For bill type 13X or 83X and revenue codes 0360-0369, a 5-position HCPCS code of 10000 - 69979 must be present unless diagnosis code V64.1, V64.2, or V64.3 is present.

For bill type 21X, 32X, 33X, or 11X (IRF facilities), HIPPS field for revenue codes specific to SNF/HHA/IRF PPS (see item f in FL 44 above).

FL 46. Units of Service

a. Up to seven numeric positions.

b. There must be an entry in this column if revenue code series 010X-016X, 020X, 021X, 0262, 0263, 0274, 0291, 030X-031X, 032X, 0333, 034X, 035X, 038X, 0403, 045X, 051X, 052X, 061X, or 080X are entered. Revenue code series 041X, 042X, 043X, 044X, 048X, 091X, 0636, and 0943 require an entry only if the first digit of FL 4 is 1-6 and the second digit of FL 4 is “4.”

d. Accommodation units must equal covered days (FL 7).

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.

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 649 and 697 through 729 only.

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, D, E, 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 program.

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 program.

FL 80 Principal Procedure Code and Date

a. If present, must be valid. 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 Date.

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; or
- Bill type is 83X or 13X and a HCPCS code is reported that is subject to the ASC.

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.

80.4 - 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.)

FIs must accumulate statistics monthly and summarize them for the entire evaluation period.

B - Procedure for Measuring and Reporting to Hospitals and SNFs

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. 1, 10-01-03)

B-02-11

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 rhildt@cms.hhs.gov, and carriers e-mail their reports to mpage1@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 flagged, 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 flagged, 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**			

80.5.2 - FI DNF Requirements

(Rev. 1, 10-01-03)

A-02-12

This section establishes a requirement for users of the Arkansas Part A Shared system (APASS). This does not apply to users of the FIFI Shared System (FISS). 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 permits the U.S. Postal Service to return Medicare checks to you free of charge.

Returned Check Process

FIs are required to use "Return Service Requested" envelopes for all checks, remittance advices and overpayment demand letters mailed to providers. FIs must be in compliance with postal regulations when developing your DNF envelopes. This initiative applies only to the "Pay To" address of each provider. Mailing addresses and physical addresses are not the major focus.

Outgoing mail must be sorted to identify provider checks, remittance advices, and overpayment demand letters and only these documents will be placed in "Return Service Requested" envelopes.

When the check is returned, if applicable, the U.S. Postal Service will provide the FI with a new address or reason for nondelivery. If a new address for the provider is supplied with the returned check, the FI does not automatically change the address of the provider or re-mail the check to the provider. (See the Change of Address process described below.)

Once an envelope is returned from the post office, the check number and any correspondence in the envelope should be recorded using normal procedures for incoming mail (for example, microfiched, or photocopied). The checks must also be logged and accounted for noting pertinent information including provider's name and number, date of check, the check number, the amount of the check and the date the check was returned.

FI financial staff will either reissue the check based upon the 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 will annotate the provider file with a DNF flag pending receipt of a verified address. Any subsequent claims submitted by flagged providers will be processed through the Common Working File (CWF) to adjudication, but no additional check, checks, or EFTs should be generated to the provider until an authorized address correction is received and the flag removed.

In addition, the provider enrollment staff must alert the fraud and abuse staff in the event that any investigations are currently taking place that are affiliated with flagged providers. The FI implements a standardized reporting format for this process.

Change of Address Process

When the flagged providers notify FIs that they have not received their checks, they should be directed to provider enrollment staff. The provider must complete the necessary sections to change their address on Form CMS-855A 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. Copies, faxes, and stamps are not acceptable. For purposes of this process, the most important address is the "Pay To" address. If the provider did not furnish the "Pay To" address on Form CMS-855A or the written notification, it must be returned and the "Pay To" address must be furnished. Addresses cannot be changed based on telephone calls.

When an address has been verified, provider enrollment staff must update the address for the provider and remove the DNF flag.

A report must be sent daily from the provider's enrollment unit to the FI financial unit advising which providers are no longer flagged DNF. Financial staff must generate all payment that is due the provider for claims that were adjudicated for the time period the provider was flagged.

80.5.2.1 - Reporting Requirements - FIs

(Rev. 1, 10-01-03)

A - Quarterly Reporting Requirements

In order to monitor the results of this initiative, FIs must submit quarterly reports to the appropriate Regional Office (RO) contact and Central Office (CO). The FI may contact (Nicole Atkins at Natkins@cms.hhs.gov). The reports are due quarterly 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).

B - The DNF Reporting Spreadsheet

Attached is a spreadsheet for FI DNF reports and related field definitions.

Field Definition

Providers Flagged/Corrected Counts

1. The number of all providers flagged for DNF during the reporting quarter that were not flagged at the end of the previous reporting quarter

2. The number of all providers who supplied a verified correct address, prompting removal of the DNF flag during the reporting quarter

3. The total number of all providers who still have a DNF flag on the last day of the reporting quarter, including those that have been flagged in a previous quarter but did not supply a verified corrected address

Check Counts

4. The total number of checks the postal service returned due to an incorrect address during the reporting quarter

5. The total number of all checks not issued because the provider was flagged DNF in the system during the reporting quarter.

6. The total number of all checks (both those the Postal Service returned and those that have been held due to a DNF flag in the system) reissued during the reporting quarter to providers who submitted a verified correct address

C - Systems Requirements

The shared systems generate the DNF reports. Shared systems and local FIs generate figures for each field in accordance with the above descriptions. Furthermore, shared systems ascertain that when the system calculates the totals, it includes the first returned check that prompted the DNF flag.

D - Stale Dating Requirements

FIs must apply the stale dating policies to any checks that remain outstanding one year after the date of issue, unless state or local banking regulations require them to be stale dated at an earlier date. Therefore, when the Postal Service returns a check as undeliverable, FIs must void the check immediately.

E - DNF Funds Held for a Calendar Year

Once a provider has been flagged for DNF, FIs may not cut any more physical checks for that provider, until the DNF flag has been removed. FIs may not send an EFT. For DNF providers, the FI holds funds up to one calendar year from the scheduled payment date only. After one calendar year has passed, FIs must cancel the payment that was held and send an adjustment claim to CWF. Sending an adjustment claim to CWF will help to balance the FI financial records.

F - Processing Subsequent Claims

FIs must process through CWF and adjudicate any subsequent claims a DNF flagged provider submits. For claims processing purposes, FIs must use the address on file to adjudicate claims submitted by DNF flagged providers. However, do not issue any

additional checks or EFTs for a DNF flagged provider until an address correction is received and the DNF flag is removed.

G - Releasing Monies After the Removal of the DNF Flag

Once the DNF flag is removed, FIs must release or issue monies in the next batch cycle due the provider for claims that were adjudicated but withheld because of the DNF flag.

H - Sample Reports

SAMPLE 1 - Blank			
Activity for the 3rd Quarter of FY 2003	**$$**	**Region**	**Medicare Contractor**
Providers Flagged/Corrected Counts			
1 # new providers flagged during the reporting quarter			
2 # providers corrected during the reporting quarter			
3 # 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			

SAMPLE 1 - Blank			
Activity for the 3rd Quarter of FY 2003	**$$**	**Region**	**Medicare Contractor**
Dollar Counts			
7 $ amount of new checks returned during the reporting quarter			
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 2 - Filled Report

Sample 2 - Filled Report			
Activity for the 3rd Quarter of FY 2003	**$$**	**Region**	**Medicare Contractor**
		Q	**XYZ Contractors**
Providers Flagged/Corrected Counts			
1 # new providers flagged during the reporting quarter	125		
2 # providers corrected during the reporting quarter	30		
3 # 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 2 - Filled Report			
Activity for the 3rd Quarter of FY 2003	**$$**	**Region**	**Medicare 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	400,000		
10 $ amount returned to trust fund during the reporting quarter	200,000		
Report By: Jane Doe			
Report Date: April 2, 2003			

90 - Patient Is a Member of an M+CO for Only a Portion of the Billing Period

(Rev. 1, 10-01-03)

HO-408, HH-412

Where a patient either enrolls or disenrolls in an M+CO (See the General Information, Eligibility, and Entitlement Manual, Chapter 5 for definition) during a period of services, two factors determine whether the M+CO 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 or home health PPS provider and the patient changes MCO status during an inpatient stay for an inpatient institution, or during the billing period for a home health agency, the patient's status at admission or start of care determines liability.

If the hospital patient was not an MCO enrollee upon admission but enrolls before discharge, the MCO is not responsible for payment.

For non-inpatient acute are PPS hospitals, if the MCO has processing jurisdiction for the MCO involved portion of the bill, it will direct the provider to split the bill and send the appropriate portions to the appropriate FI or MCO. When forwarding a bill to an MCO, the provider must also submit the necessary supporting documents.

If the provider is not a PPS provider, the MCO 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 MCO before start of care, the MCO 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 MCO enrollee upon admission but enrolls before discharge, the MCO is not responsible for payment.

If the provider is not a PPS provider, the MCO is responsible for payment for services on and after the day of enrollment up through the day that disenrollment is effective.

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:
    - Retains employment rights in the industry;
    - Has not had employment terminated by the employer,
    - Is not receiving disability payments from an employer for more than six months;
    - Is not receiving social security disability benefits; and
    - 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. 1, 10-01-03)

A3-3670, PM AB-00-38

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

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.

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;
- Initiate appropriate recovery action;
- Instruct the provider to refund to the beneficiary any Part B deductible and/or coinsurance collected, or use the indemnification process, as appropriate; and
- Determine what data is needed to support repayment or cancel action on the claim.

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

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. 1, 10-01-03)

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).
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. For electronic UB-92, the biller enters the claim change reason code as a

condition code on record type 41 in fields 4-13. 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. 1, 10-01-03)

HO-411.3, HO-IM411.3

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, r
- 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;

- 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, 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 PPSproviders. 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. 1, 10-01-03)

A3-3664, HO-411.1, HO-IM411.1, HH-445, A3-3610.8, HO-415.11

For hard copy UB-92 adjustment requests, the hospital places the ICN/DCN of the original bill in FL 37 for Payer A, B, or C. For EMC bills in CMS national UB-92 format (version 060), the hospital must submit the ICN/DCN of the original bill in Record Type 31, positions 155-177.

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 it's 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. 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 - Adjustment to HIPPS Codes Resulting From MDS Corrections

(Rev. 1, 10-01-03)

SNF-515.5

The MDS is an assessment tool completed by facility clinical staff that is transmitted electronically to state agencies and then transferred to CMS, and is used to determine a Resource Utilization Group (RUG-III) code. Effective for services provided on and after June 1, 2000, SNFs must submit adjustment requests to reflect corrections to the MDS data that result in changes to the RUG-III code (i.e., the first three digits of the HIPPS code).

When the SNF PPS was implemented in July 1998, there were limited options for facilities to correct an incorrect response in the MDS record that was used to calculate the RUG-III group, even when that error resulted in an incorrect payment rate. Instructions on the types of errors SNFs may correct within the MDS assessment tool are available at http://cms.hhs.gov/medicaid/mds20/mdsimple.pdf under Data Specifications and Instructions. The document is titled "March 2000 Draft Instructions for Making Automated Corrections Using the New MDS Correction Request Form."

Correction to MDS data may affect items that are used in the RUG-III grouper calculations, and could change the RUG-III group for which a beneficiary qualifies. An example of a valid correction would be a change to MDS2.0 item M1b, number of stage 2 ulcers. If the facility reported zero Stage 2 ulcers when there were really 3 ulcers present, the item should be corrected using the process explained in the procedures on the website we indicated in the preceding paragraph.

An adjustment request with an Adjustment Reason Code of D2 must be submitted if the MDS correction results in a RUG-III code that is different from that already paid. The adjustment request corrects payment on the first (incorrect) bill. The SNF uses the old assessment date and the FI re-prices the claim based on the corrected RUG-III code.

EXAMPLE 1

A Medicare 5-day assessment was completed timely and used to establish the RUG-III rate for days 1-14 of the Part A stay. The bill was paid before the provider found the error. (The error on that 5-day assessment was identified on day 17 while staff was

completing the Medicare 14-day assessment.) The facility corrects the 5-day assessment, and submits an adjustment request for days 1-14 of the Part A stay.

EXAMPLE 2

On day 39 of the Part A stay, the facility identifies an error in a 30-day Medicare MDS. Five days of service had already been billed and paid based on the HIPPS code generated from that 30-day Medicare assessment. The facility submits an MDS correction to the state that results in a change in the RUG-III group. The SNF also submits an adjustment request to the FI for the 5 days of service using the corrected RUG-III group. Then, the corrected RUG-III code is used for billing any remaining covered days in the applicable payment period.

Unlike the significant correction of prior assessment, an MDS correction is not a new assessment and cannot be used as a replacement for the next regular Medicare assessment.

SNFs must document the reason for the MDS correction and certify to the accuracy of the correction. This documentation must be kept in the medical record. Review of the documentation on the reason for correction must be incorporated into the FI medical review process.

To meet the clinical MDS requirements, SNFs may be required to perform a Significant Change in Status Assessment (SCSA) or a Significant Correction of Prior Assessment (SCPA) in addition to completing the MDS correction. As long as the RUG-III group generated from the MDS correction and the SCSA or SCPA are the same, the SNF can use the corrected assessment to bill any remaining covered days in the applicable payment period (e.g., days 31-60 for the 30-day assessment). However, since the SCSAs and the SCPAs require a new observation period and new assessment reference dates, it is possible that the RUG-III group generated by the SCSA or SCPA assessment will be different. In this case, the corrected assessment would be used from the first day of the applicable payment period (e.g., days 31-60 for the 30-day assessment) until the assessment reference date of the SCSA or SCPA assessment. If the assessment reference date for the SCSA or SCPA is within the assessment window, the SCSA or SCPA must also be used as a replacement for the next regular assessment.

MDS corrections may also be processed to inactivate an MDS record. Some examples of records that should be inactivated include assessment data submitted under the HICN for a different beneficiary, or a record transmitted with the wrong reason for assessment. In most cases, the SNF will also have filed an accurate, timely MDS for the beneficiary, which can be used for billing purposes. If the SNF did not realize the error until a bill had been submitted and paid, the SNF would submit an adjustment request. However, this type of adjustment does not involve a correction of MDS clinical data, and is not subject to the clinical data correction procedures described above. This type of adjustment request would also use adjustment code D2. In those rare situations where an MDS is inactivated and there is no valid MDS for that payment period, the SNF must bill the adjustment at the default rate for the applicable time period.

130.3.1.1 - Effective Date for Adjustment Billing for SNF PPS Bills

(Rev. 1, 10-01-03)

Beginning June 1, 2000, when an MDS modification or inactivation results in a change in the RUG-III group and HIPPS code used on a previously paid claim, the SNF must submit an adjustment request. This policy only refers to Medicare skilled services that were provided in the SNF on June 1, 2000, or later. Therefore, HIPPS codes based on service dates (FL 45 on the bill) beginning prior to June 1, 2000 may not be adjusted based on a correction to the relevant MDS. If this type of adjustment request (condition code D2) is submitted for service dates prior to June 1, 2000, it will be returned to the provider (RTPed). The report message is, "An adjustment request based on a corrected MDS cannot be processed for service dates prior to June 1, 2000."

The "through" date will be used to calculate the period during which adjustment requests may be submitted based on corrected MDS assessments. The "through" date indicates the last day of the billing period for which the HIPPS code is billed. Adjustment bills based on corrected MDS assessments must be submitted within 120 days of the "through" date on the bill. An edit is in place to limit the time for submitting this type of adjustment request to 120 days from the service "through" date.

We expect that most MDS corrections will be made during the course of the beneficiary's Medicare Part A stay. Therefore, providers that routinely submit MDS corrections after the beneficiary's Part A stay has ended may be subject to focused medical review.

Adjustment bills to change a HIPPS code may not be submitted for any claim that has already been medically reviewed. SNFs determine medical review occurred on a claim depending on whether the FI requested medical records. FI changes in the HIPPS code by medical reviewers as well as claim denials (partial or full) for medical necessity may not be adjusted. These claims are identified on the remittance with specific remark codes to indicate denial or HIPPS code changes. This applies whether or not the medical review was performed either prepay or post-payment. All adjustment requests submitted may be subject to medical review. Information regarding medical review is located in the Program Integrity Manual found at the following Internet address: http://cms.hhs.gov/manuals/108_pim/pim83toc.asp

Isolated billing errors on a single MDS prior to June 1, 2000 cannot be adjusted. However, the requirement that providers may not knowingly over-bill the Medicare program remains in effect. SNFs that identify patterns of errors that result in overpayments must report them to the FI, and these overpayments must be recouped. A pattern of errors includes but is not limited to software errors in transmitting MDS files, misunderstandings of MDS instructions that result in consistent miscoding of one or more MDS items used in determining the RUG-III group, etc.

130.3.1.2 - Tolerance Guides for Submitting SNF Inpatient Adjustment Requests

(Rev. 1, 10-01-03)

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.)

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 Paper Claims

(Rev. 1, 10-01-03)

1. FL 4. Type of Bill is 217, (replacement bill).

2. FL 37. 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" in FL 37. Similarly, the ICN/DCN for Payer's B and C must be shown on lines B and C respectively, in FL 37.

3. FLs 24, 25, 26, 27, 28, 29, and 30: Condition Code D2, Change in Revenue code/HCPCS or HIPPS, will be used.

4. The adjustment claim will reflect the corrected RUG-III group by changing the HIPPS code associated with that assessment.

5. The provider must submit an entire replacement debit.

130.3.3 - SNF Inpatient Electronic Claims Using the UB-92 National Format (Version 060)

(Rev. 1, 10-01-03)

1. Type of bill 217 is placed in Record type 40, Field No. 4.

2. The provider submits the ICN/DCN of the original bill in Record Type 31, Field No. 14.

3. Condition Code D2 will be entered in Record Type 41, Field No. 4-10. Other condition codes may be necessary on the claim and can be repeated 10 times.

4. The adjustment claim will reflect the corrected RUG-III group by changing the HIPPS code associate with that assessment.

5. The provider must submit an entire replacement debit.

130.3.3.1 - Billing Instructions-SNF Inpatient Electronic Claims Using the ANSI X12N 837 (Version 3051)

(Rev. 1, 10-01-03)

1. Type of bill is placed in 2-130-CLM05-01 and 2-130-CLM05-03.

2. The provider submits the ICN/DCN of the original bill in 2-180.A-REF02 and 2-355.AC-REF02.

3. The Condition Code (D2) will be placed in 2-225.E-H101-02. Other condition codes may be necessary on the claim and can be repeated up to 9 times.

4. The adjustment claim will reflect the corrected RUG-III group by changing the HIPPS code associated with that assessment.

5. The provider must submit an entire replacement debit.

130.3.3.2 - Billing Instructions-SNF Inpatient Electronic Claims Using the ANSI X12N 837 (HIPAA Version)

(Rev. 1, 10-01-03)

1. Type of bill is placed in 2300-CLM05-01 and 2300-CLM05-03.

2. The provider submits the ICN/DCN of the original bill in 2300 REF02 and 2330B-REF01 128F8.

3. The Condition Code (D2) will be placed in 2300HI01 C022-02. Other condition codes may be necessary on the claim and can be repeated up to 9 times.

4. The adjustment claim will reflect the corrected RUG-III group by changing the HIPPS code associated with that assessment.

5. The provider must submit an entire replacement debit.

130.3.4 - Patient Does Not Return From SNF Leave of Absence, and Last Bill Reported Patient Status as Still Patient (30)

(Rev. 1, 10-01-03)

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) in FL 22 of 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 (FL 22) 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.

Exhibit 1 - Data Element Requirements Matrix (Carrier)

(Rev. 1, 10-01-03)

B3-3999

CLAIMS WILL BE RETURNED AS UNPROCESSABLE IF THE FOLLOWING INFORMATION IS INCOMPLETE/INVALID:

CMS 1500	NSF	PAPER	EMC	*STATUS	**CARRIER/DMERC ACTION ON RETURNED CLAIM
1A	DAO-18.0	Insured I.D. Number	Insured I.D. Number	R	
2	CAO-04.0	Patient Name	Patient Last Name	R	Note: For Medicare purposes the Patient and the Insured are always the same. The insured's name is pulled from CA0-04 & 05. Therefore the following fields are not edited: DA2-04.0 DA2-06.0 DA2-07.0 DA2-08.0 DA2-09.0 CA0-17.0 CA0-18.0 CA0-19.0

CMS 1500	NSF	PAPER	EMC	*STATUS	**CARRIER/DMERC ACTION ON RETURNED CLAIM
					DA0-11.0 EA0-07.0 EA0-15.0 EA0-16.0 FB1-06 FB1-07 FB1-13.0 FB1-09.0 FB0-22.0 FA0-20.0 FA0-21.0 FA0-31.0 BA0-19.0 BA0-20.0 BA0-18.0 BA1-13.0

CMS 1500	NSF	PAPER	EMC	*STATUS	**CARRIER/DMERC ACTION ON RETURNED CLAIM
					BA1-15.0 BA0-16.0 BA1-17.0 BA1-18.0
	CAO-05.0		Patient First Name	R	
4	DAO-19.0	Insured Name	Insured Last Name	C	Note: Data element not mapped to MCS claim
	DAO-20.0		Insured First Name	C	Note: Data element not mapped to MCS claim
6	DAO-17.0	Patient Relationship to Insured	Same	C	Note: Data element not mapped to MCS claim
11		Insured Policy Group Number		R	
	DAO-10.0	Insured Policy Group Number	Group Number	C	
	DAO-05.0		Source of Payment	R	
12	DAO-16.0	Patient Signature Source	Patient Signature Source	R	
	EAO-13.0		Release of Information Indicator	R	
14	GCO-05.0			C	

CMS 1500	NSF	PAPER	EMC	*STATUS	**CARRIER/DMERC ACTION ON RETURNED CLAIM
17	EAO-24	Name of Refer/Ordering Provider	Refer/Ordering Provider Last Name	C	
17A	EAO-21.0		Referring Provider UPIN	C	
		OR			
	EA1-16.0		Supervising Provider	C	
19	EAO-48.0	Reserved for Local Use	Date Last Seen	C	
	FB1-22.0		Supervising Provider UPIN	C	
	GCO-06.0		Date of Last X-Ray	C	
	EAO-50.0		Homebound Indicator	C	
20	EAO-30.0	Outside Lab	Laboratory Indicator	C	Note: Not mapped to the claims screen
	EAO-31.0		Lab Charges	C	Note: Not mapped to the claims screen
	FAO-26.0		Purchased Service Indicator	C	
	FBO-05.0		Purchased Service Charge	C	
21	EAO-32.0	Diagnosis	Diagnosis-1	C	
	EAO-33.0		Diagnosis-2	C	
	EAO-34.0		Diagnosis-3	C	

CMS 1500	NSF	PAPER	EMC	*STATUS	**CARRIER/DMERC ACTION ON RETURNED CLAIM
	EAO-35.0		Diagnosis-4	C	
22		Medicaid Resubmission Code		NR	
23		Prior Authorization		C	
24A	FAO-05.0	Dates of Service(s)	Service From Date	R	
24B	FAO-07.0	Place of Service	Place of Service Code	R	
24C	FAO-08.0	Type of Service	Type of Service Code	NR	
24D	FAO-09.0	Procedures, Services, etc.	HCPCS Procedure Code	R	
	FAO-10.0		HCPCS Modifier 1	C	
	FAO-11.0		HCPCS Modifier 2	C	
	FAO-12.0		HCPCS Modifier 3	C	
	FAO-36.0		HCPCS Modifier 4	C	
24G	FAO-18.0	Days or Units of Service	Units of Service	R	
		OR			
	FAO-19.0			R	
24K	FAO-23.0	Reserved for Local Use	Rendering Provider UPIN	C	
27	EAO-36.0	Accept Assignment	Provider Assignment Indicator	NR	

CMS 1500	NSF	PAPER	EMC	*STATUS	**CARRIER/DMERC ACTION ON RETURNED CLAIM
31	EAO-37.0	Provider Signature Indicator	Provider Signature Indicator	R	
32	EAO-39.0	Facility Name and Address	Facility/Laboratory Name	C	
			AND/OR		
	EA1-04.0		Facility/Laboratory UPIN Number	C	
		OR			
	FBO-11.0		Laboratory I.D.	C	
33	BA1-16.0		Provider's Pay-To State	R	
		OR			
	BAO-09.0	Provider's Billing Name & Address	Provider Medicare UPIN No. (Batch)	R	

*R = Required - information which MUST always be on a claim.

C = Conditional - information which is required on a claim if certain conditions exist.

NR = Not Required - information which is required on a claim if certain conditions exist.

**Lists the action each Medicare Carrier or DMERC will take on a claim returned as unprocessable (for instance, suspending a claim returned as unprocessable).

Exhibit 2 - Data Element Requirements Matrix (FI)

(Rev. 1, 10-01-03)

A3-3600, Addendum L

Claims Will Be Returned To The Provider (RTP) If The Following Information Is Incomplete/Invalid:

EMC Loop: Segment: Element*	**Paper Form Locator**	**Data Elements Description**	**Hospital**							**SNF**		
			I	**O**	**H**	**C/OP**	**RHC FQHC**	**HH**	**RD**	**I**	**O**	**RN**
2010AA all segments	1	Provider Name, Address, Phone #	R	R	R	R	R	R	R	R	R	R
n/a	2	Untitled	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
2300:CLM01	3	Patient Control Number	R	R	R	R	R	R	R	R	R	R
2300:CLM05	4	Type of Bill	R	R	R	R	R	R	R	R	R	R
2010AA:NM108	5	Federal Tax Number	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
2300:DTP03:434 qualifier	6	Statement Covers Period (from-through)	R	R	R	R	R	R	R	R	R	R
2300:QTY01:CA qualifier	7	Covered Days	R	NR	NR	NR	NR	NR	NR	R	NR	R
2300:QTY01:NA qualifier	8	Noncovered Days	R	NR	NR	NR	NR	NR	NR	R	NR	R
2300:QTY01:CD qualifier	9	Coinsurance Days	R	NR	NR	NR	NR	NR	NR	C	NR	C
2300:QTY01:LA qualifier	10	Lifetime Reserve Days	R	NR	NR	NR	NR	NR	NR	C	NR	C
n/a	11	Untitled	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR

EMC Loop: Segment: Element*	Paper Form Locator	Data Elements Description	Hospital							SNF		
			I	O	H	C/OP	RHC FQHC	HH	RD	I	O	RN
2010CA:NM103:QC qualifier	12	Patient's Name	R	R	R	R	R	R	R	R	R	R
2010CA:N301	13	Patient's Address	R	R	R	R	R	R	R	R	R	R
2010CA:DMG02:D8 qualifier	14	Patient's Birthdate	R	R	R	R	R	R	R	R	R	R
2010CA:DMG03:D8 qualifier	15	Patient Sex	R	R	R	R	R	R	R	R	R	R
not used	16	Patient's Marital Status	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
2300:DTP03:435 qualifier	17	Admission Date	R	NR	R	NR	NR	R	NR	R	NR	R
2300:DTP03:435 qualifier	18	Admission Hour	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
2300:CL101	19	Type of Admission	R	NR	NR	NR	NR	NR	NR	R	NR	R
2300:CL102	20	Source of Admission	R	R	NR	NR	NR	R	NR	R	NR	R
2300:DTP03:096 qualifier	21	Discharge Hour	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
2300:CL103	22	Patient Status	R	R	R	NR	NR	R	NR	R	R	R
2300:REF02:EA qualifier	23	Medical Record Number	C	C	C	C	C	C	C	C	C	C
2300:HI01:BG qualifier	24-30	Condition Codes	C	C	C	C	C	C	C	C	C	C
n/a	31	Untitled	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR

EMC Loop: Segment: Element*	Paper Form Locator	Data Elements Description	Hospital							SNF		
			I	O	H	C/OP	RHC FQHC	HH	RD	I	O	RN
2300:HI01:BH	32-35	Occurrence Codes and Dates	C	C	C	C	C	C	C	C	C	C
2300:HI01:BI	36	Occurrence Span Code and Dates	C	C	C	C	C	C	C	C	C	C
2300:REF02:F8 qualifier	37	Internal Control # (ICN)/Document Control # (DCN)	C	C	C	C	C	C	C	C	C	C
2010BD all segments	38	Responsible Party Name and Address	C	C	C	C	C	C	C	C	C	C
2300:HI01:BE qualifier	39-41	Value Codes and Amounts	C	C	C	C	C	C	C	C	C	C
2400:SV201	42	Revenue Code	R	R	R	R	R	R	R	R	R	R
n/a	43	Revenue Description	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
2400:SV202	44	HCPCS/HIPPS/Rates	C	C	C	C	C	C	C	C	C	C
2400:DTP03	45	Service Date	NR	C	C	C	C	C	C	NR	C	C
2400:SV205	46	Service Units	R	R	R	R	R	R	R	R	R	R
2400:SV203	47	Total Charges	R	R	R	R	R	R	R	R	R	R
2400:SV207	48	Noncovered Charges	C	C	C	C	C	C	C	C	C	C
n/a	49	Untitled	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
2010BC:NM103	50	Payer Identification	R	R	R	R	R	R	R	R	R	R
2010AA:REF01:1A qualifier	51	Provider Number	R	R	R	R	R	R	R	R	R	R

EMC Loop: Segment: Element*	Paper Form Locator	Data Elements Description	Hospital							SNF		
			I	O	H	C/OP	RHC FQHC	HH	RD	I	O	RN
qualifier												
2300:CLM09	52	Release of Information	R	R	R	R	R	R	R	R	R	R
2300:CLM08	53	Assignment of Benefits Certification Indicator	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
2300:AMT02:C5 qualifier	55	Estimated Amount Due	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
n/a	56	Untitled	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
n/a	57	Untitled	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
2010AA:NM103:IL qualifier	58	Insured's Name	R	R	R	R	R	R	R	R	R	R
2320:SBR02	59	Patient's Relationship to Insured	C	C	C	C	C	C	C	C	C	C
2010:NM109	60	Certificate/Social Security #/HI Claim/Identification #	R	R	R	R	R	R	R	R	R	R
2320:SBR04	61	Group Name	C	C	C	C	C	C	C	C	C	C
2000:SBR02	62	Insurance Group Number	C	C	C	C	C	C	C	C	C	C
2300:REF02	63	Treatment Authorization Number	NR	NR	NR	NR	NR	R	NR	NR	NR	NR
2320:SBR01	64	Employment Status Code	C	C	C	C	C	C	C	C	C	C
2320:SBR01	65	Employer Name	C	C	C	C	C	C	C	C	C	C

EMC Loop: Segment: Element*	Paper Form Locator	Data Elements Description	Hospital							SNF		
			I	O	H	C/OP	RHC FQHC	HH	RD	I	O	RN
2320:SBR01	66	Employer Location	C	C	C	C	C	C	C	C	C	C
2300:HI01:BK qualifier	67	Principal Diagnosis Code	R	R	R	R	R	R	R	R	R	NR
2300:HI01:BF qualifier	68-75	Other Diagnosis Codes	C	C	C	C	C	C	C	C	C	NR
2300:HI02:BJ qualifier	76	Admitting Diagnosis	R	NR	NR	NR	NR	NR	NR	R	NR	NR
2300:HI03:BN qualifier	77	E-Code	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
n/a	78	Untitled	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
n/a	79	Procedure Coding Method	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
2300:HI01:BP qualifier	80	Principal Procedure Code	C	NR	NR	NR	NR	NR	NR	NR	NR	NR
2300:HI01:BO qualifier	81	Other Procedure Codes and Dates	C	NR	NR	NR	NR	NR	NR	NR	NR	NR
2310A:NM101:71 qualifier	82	Attending/Referring Physician I.D.	R	R	R	R	R	R	R	R	R	NR
2310B:NM103:72 qualifier	83	Other Physician I.D. (1)	C	C	C	C	C	NR	C	C	C	NR
2310C:NM103:73 qualifier	83	Other Physician I.D. (2)	C	C	C	C	C	NR	C	C	C	NR
2010:N301	84	Remarks	C	C	C	C	C	C	C	C	C	C
n/a	85	**Provider Representative Signature	R	R	R	R	R	NR	R	R	R	R

EMC Loop: Segment: Element*	Paper Form Locator	Data Elements Description	Hospital							SNF		
			I	O	H	C/OP	RHC FQHC	HH	RD	I	O	RN
n/a	86	**Date	R	R	R	R	R	NR	R	R	R	R

* -- Includes qualifier if segment and element are repeated in the same loop

** -- Required only for hardcopy

KEY:

R=Required; NR=Not required; C=Conditional

These indicators represent Medicare requirements only. Additional data elements may be required by the 837 claim implementation guide.

Hospital: I=Inpatient and O=Outpatient; H=Hospice; C/OP=CORF/CMHC/Outpatient Physical Therapy

RH/FQ=Independent Rural Health Clinics/Free--Standing Federally Qualified Health Centers

HH=Home Health Agency; RD=Renal Dialysis Facility (Nonhospital Operated)

Skilled Nursing Facility: I=Inpatient and O=Outpatient; RN=Religious Nonmedical Health Care Institution