



Correction to Processing of Non-Covered Revenue Codes – JA6774

Note: MLN Matters® article MM6774 was revised to reflect the release of revised Change Request (CR) 6774. The transmittal number, CR release date and the link to the transmittal were changed.

Related CR Release Date: March 5,, 2010 **Revised**

Date Job Aid Revised: March 12, 2010

Effective Date: July 1, 2010

Implementation Date: July 6, 2010

Key Words MM6774, CR6774, R1928CP, Non-Covered, Revenue

Contractors Affected

- Part A/B Medicare Administrative Contractors (A/B MACs)
- Fiscal Intermediaries (FIs)
- Regional Home Health Intermediaries (RHHIs)

Provider Types Affected

All providers and suppliers submitting claims to FIs, RHHIs, and A/B MACs for Medicare beneficiaries



- CR6774 explains that claims processed on or after July 6, 2010, that contain an institutional service line submitted with a revenue code that is not valid for Medicare billing will only be returned to the provider if the line is submitted with covered charges or the claim indicates that beneficiary liability may apply.
- CR6774 also contains miscellaneous clarifications to Chapter 1, General Billing Requirements, in the *Medicare Claims Processing Manual*.

Provider Needs to Know...

- Medicare systems will be changed so that a revenue code line submitted with entirely non-covered charges and no indication that beneficiary liability may apply will not be returned to the provider.
 - Such claims should be processed to completion without payment, assigning liability to the provider.
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Background

- In October 2004, the Centers for Medicare & Medicaid Services (CMS) issued Transmittal 332 (CR3416), entitled “New Policy and Refinements on Billing Non-covered Charges to Fiscal Intermediaries (FIs).”
- This transmittal completed a series of instructions that established requirements for processing non-covered charges on institutional claims and for correctly assigning financial liability for non-covered charges.
- One underlying premise of those instructions was that any institutional provider should be able to submit a claim line with non-covered charges for any service that the provider delivered and that Medicare systems should process that non-covered line to completion without payment. This premise is consistent with the goals of administrative simplification and increasing automated coordination of benefits across various payers.
- Those instructions contained one significant omission in that they did not take into account the fact that Medicare systems currently determine whether a particular revenue code is valid for Medicare billing without regard to whether the revenue code line is submitted as non-covered.
- Each Medicare contractor that processes institutional claims maintains a revenue code file, which lists the revenue codes that are valid for each type of bill.
- If a provider submits a claim with a revenue code that is not listed on the revenue code file as valid for the submitted type of bill, the claim is returned to the provider.
- This should happen when the revenue code line is submitted with covered charges, but the claim should not be returned if it is submitted entirely with non-covered charges.

Operational
Impact

N/A

Reference
Materials

The related MLN Matters® article can be found at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6774.pdf> on the CMS website.

The official instruction (CR6774) regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1928CP.pdf> on the CMS website. Miscellaneous clarifications to Chapter 1, General Billing Requirements, in the *Medicare Claims Processing Manual* and those clarifications, which do not change any Medicare policies, are attached to CR6774.