



News Flash – The Centers for Medicare & Medicaid Services (CMS) reminds all providers, physicians, and suppliers to allow sufficient time for the Medicare crossover process to work—approximately 15 work days after Medicare’s reimbursement is made, as stated in MLN Matters Article SE0909 (<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0909.pdf>) — before attempting to balance bill their patients’ supplemental insurers. That is, do not balance bill until you have received written confirmation from Medicare that your patients’ claims will not be crossed over, or you have received a special notification letter explaining why specified claims cannot be crossed over. Remittance Advice Remark Codes MA18 or N89 on your Medicare Remittance Advice (MRA) represent Medicare’s intention to cross your patients’ claims over.

MLN Matters® Number: MM6774 **Revised**

Related Change Request (CR) #: 6774

Related CR Release Date: March 5, 2010

Effective Date: July 1, 2010

Related CR Transmittal #: R1928CP

Implementation Date: July 6, 2010

Correction to Processing of Non-Covered Revenue Codes

Note: This article was updated on November 20, 2012, to reflect current Web addresses. This article was previously revised on March 5, 2010 to reflect the release of a revised Change Request. The transmittal number, CR release date and the link to the transmittal were changed. All other information is the same.

Provider Types Affected

All providers and suppliers submitting claims to Medicare contractors (fiscal intermediaries (FI), Regional Home Health Intermediaries (RHHI), and A/B Medicare Administrative Contractors (MAC)) for Medicare beneficiaries are affected.

Provider Action Needed

This article, based on CR6774, explains that claims containing 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. Affected providers should

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ensure that their billing staffs are aware of these changes that are effective for claims processed on or after July 6, 2010.

Background

In October 2004, CMS issued Transmittal 332, Change Request (CR) 3416, 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.

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. CR 6774 revises Medicare systems to ensure this outcome. CR 6774 also contains 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 CR 6774.

Additional Information

If you have questions, please contact your Medicare contractor at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the Centers for Medicare & Medicaid Services (CMS) website.

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The official instruction, (CR 6774), issued to your Medicare contractor regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1928CP.pdf> on the CMS website.

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