



**News Flash** – The Centers for Medicare & Medicaid Services (CMS) recently issued a final rule that will change how Medicare pays for dialysis services for Medicare beneficiaries who have end-stage renal disease (ESRD). CMS also issued a proposed rule that would establish a new quality incentive program (QIP) to promote high quality services in dialysis facilities by linking a facility's payments to performance standards. The QIP is the first pay-for-performance program in a Medicare fee-for-service payment system. For additional information please see the CMS Fact sheet (7/26) at [http://www.cms.gov/apps/media/fact\\_sheets.asp](http://www.cms.gov/apps/media/fact_sheets.asp) on the CMS website.

MLN Matters® Number: MM6874

Related Change Request (CR) #: 6874

Related CR Release Date: August 20, 2010

Effective Date: November 29, 2010

Related CR Transmittal #: R2031CP

Implementation Date: November 29, 2010

**Note:** This article was updated on November 30, 2012, to reflect current Web addresses. All other information remains unchanged.

## Beneficiary-Submitted Claims

### Provider Types Affected

All physicians, providers, and suppliers submitting claims to Medicare contractors (carriers and A/B Medicare Administrative Contractors (MAC)) for services provided to Medicare beneficiaries are affected by this issue.

### Provider Action Needed

This article, based on CR 6874, clarifies instructions for processing claims by carriers and A/B MACs that are submitted by Medicare beneficiaries. All providers and suppliers are required to enroll in the Medicare program in order to receive payment. In addition, Section 1848 (g)(4)(A) of the Social Security Act requires all providers and suppliers submit claims for services rendered to Medicare beneficiaries. The current manual requirement instructs Medicare contractors how to process claims submitted by Medicare beneficiaries when the provider or supplier refuses to submit claims for services rendered and/or refuses to enroll in Medicare.

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Medicare contractors will also provide education to the Medicare beneficiaries on how to submit complete claims, including all supporting documentation. Please inform your billing staffs of these instructions. **These requirements apply to all claims received on or after November 29, 2010, without regard to the date of service.**

**Note: These instructions do not apply to foreign claims or Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) claims.**

## Background

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Medicare contractors will:

- 1) Process beneficiary-submitted claims for services that are not covered by Medicare (e.g., for hearing aids, cosmetic surgery, personal comfort services; see 42 CFR 411.15 for details at [http://edocket.access.gpo.gov/cfr\\_2002/octqtr/42cfr411.15.htm](http://edocket.access.gpo.gov/cfr_2002/octqtr/42cfr411.15.htm) on the Internet), in accordance with its normal processing procedures.
- 2) Process beneficiary-submitted claims for services that are covered by Medicare when the beneficiary has submitted a complete claim on Form CMS-1490S, which is available at <http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1490s-english.pdf> on the Centers for Medicare & Medicaid Services (CMS) website, and all supporting documentation associated with the claim, including an itemized bill with the following information:
  - Date of service;
  - Place of service;
  - Description of illness or injury;
  - Description of each surgical or medical service or supply furnished;
  - Charge for each service;
  - The doctor's or supplier's name and address; and
  - The provider or supplier's National Provider Identifier (NPI).

Since there is no place on Form CMS-1490S to insert a provider or supplier's NPI, claims submitted by the beneficiary without the provider or supplier's NPI will not be considered incomplete. The contractor will use the NPI registry to locate the provider or supplier's NPI. If the contractor determines that the provider or supplier was not a Medicare enrolled provider with a valid NPI, contractors will follow previously established procedures in order for the claim to be processed and adjudicated through the claims processing system. If an incomplete claim or a claim containing invalid information is submitted, the contractor will return the claim as incomplete with an appropriate letter to the

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beneficiary that communicates the specific items listed above which were missing or invalid.

- 3) When returning a beneficiary-submitted claim (Form CMS-1490S) for a Medicare-covered service because the claim is not complete or contains invalid information, the contractor will retain the Form CMS-1490S and supporting documentation for purposes of the timely filing rules in the event that the beneficiary resubmits the claim (see below).

When returning a beneficiary-submitted claim, the contractor will also inform the beneficiary, by letter, that the provider or supplier is required by law to submit a claim on behalf of the beneficiary (for services that would otherwise be payable), and that in order to submit the claim, the provider must enroll in the Medicare program. In addition, contractors should encourage beneficiaries to always seek non-emergency care from a provider or supplier that is enrolled in the Medicare program. If a beneficiary receives services from a provider or supplier that refuses to submit a claim on the beneficiary's behalf (for services that would otherwise be payable by Medicare), and/or refused to enroll in Medicare, the beneficiary should:

- 1) Notify the contractor in writing that the provider or supplier refused to submit a claim to Medicare; and
- 2) Submit a complete Form CMS-1490S with all supporting documentation.

Medicare contractors will process and pay the beneficiary's claim if it is for a service that would be payable by Medicare were it not for the provider's or supplier's refusal to submit the claim and/or enroll in Medicare. The only exception would be for sanctioned and opt-out providers. Payment may only be made on the first claim submitted for services provided by an excluded/sanctioned or opt-out provider. No further payments will be made for services rendered by such providers after the first claim is paid.

Contractors will maintain documentation of beneficiary complaints involving violations of the mandatory claims submission policy and a list of the top 50 violators, by State, of the mandatory claim submission policy.

## Additional Information

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If you have questions, please contact your Medicare carrier and/or MAC 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>

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on the CMS website. The official instruction, CR 6874, issued to your Medicare carrier and/or MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2031CP.pdf> on the CMS website.

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