Reference Guide for Medicare Physician & Supplier Billers

Helping Front Office Personnel Navigate Medicare Rules for Part B Claims Processing

First Edition - April 2004

REFERENCE GUIDE FOR MEDICARE PHYSICIAN & SUPPLIER BILLERS

HELPING FRONT OFFICE PERSONNEL NAVIGATE
MEDICARE RULES FOR PART B CLAIMS PROCESSING

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DISCLAIMER

This guide is designed to provide accurate and authoritative information with regard to the subjects covered, and every reasonable effort has been made to assure the accuracy of the information within these pages. However, the ultimate responsibility for correct coding/documentation lies with the provider of services.

The Centers for Medicare & Medicaid Services' (CMS') employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free, nor that the use of this handbook will prevent differences of opinion or disputes with the Medicare carrier/fiscal intermediary (FI) as to the codes that are accepted or the amounts that will be paid to providers of services, and will bear no responsibility or liability for the results or consequences of the use of this book. The *Reference Guide for Medicare Physician & Supplier Billers* explains the Medicare Program but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings.

American Medical Association Notice and Disclaimer

ICD-9 Notice

The *Reference Guide for Medicare Physician & Supplier Billers* was prepared as a service to the public and is not intended to grant rights or impose obligations. The guide may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statures, regulations, and other interpretive materials for a full and accurate statement of their contents.

FOREWORD

Medicare Reform and the Change from HCFA to CMS

During the first wave of reforms designed to strengthen the healthcare services and information available to nearly 70 million Medicare and Medicaid beneficiaries and the providers who serve them, the Health Care Financing Administration (HCFA) was renamed the Centers for Medicare & Medicaid Services (CMS) in June 2001. The name change marks the first of many steps being taken to become a more responsive and effective Agency that is refocused along its three primary lines of service:

- **The Center for Medicare Management** - focuses on management of traditional fee-for-service Medicare to include development of payment policy and management of the Medicare fee-for-service contractors;
- **The Center for Beneficiary Choices** - focuses on providing beneficiaries with information on Medicare, Medicare Select, Medicare Advantage, and Medigap options to include management of the Medicare Advantage plans, consumer research and demonstrations, and grievance and appeals functions; and
- **The Center for Medicaid and State Operations** - focuses on programs administered by states to include Medicaid, the State Children's Health Insurance Program (SCHIP), insurance regulation functions, survey and certification, and the Clinical Laboratory Improvement Amendments (CLIA).

CMS Mission

The new name also reflects the scope of the Agency's mission - to assure healthcare security for Medicare and Medicaid beneficiaries.

CMS Vision

In serving beneficiaries, CMS will open its programs to full partnership with the entire health community to improve quality and efficiency in an evolving healthcare system.

CMS Goals

The Agency's goals are to:

- Protect and improve beneficiary health and satisfaction;
- Promote appropriate and predictable payments and high quality care;
- Promote understanding of CMS programs among beneficiaries, the healthcare community, and the public;
- Foster excellence in the design and administration of CMS programs; and
- Provide leadership in the broader healthcare marketplace to improve health.

To support the mission, vision, and goals of the Agency, CMS launched the following website in September 2001:

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

This website is a valuable resource that provides information for the healthcare community on the Agency's programs, initiatives, and priorities.

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PREFACE

DISCLAIMER

This guide addresses the submission of Medicare Part B claims by physicians and suppliers. For the purposes of this guide, references to the term "provider" generally apply to all physicians or suppliers, unless otherwise specified.

What Is a Part A Medicare Provider?

Medicare defines Part B providers as physicians and suppliers. Part A providers are institutions, including hospitals, Skilled Nursing Facilities (SNFs), home health agencies (HHAs), comprehensive outpatient rehabilitation facilities, and others. Although Part A providers bill for Part B services in some situations, their specific billing procedures differ from those of physicians and suppliers, and therefore will not be discussed within this guide.

What Information is Included within this Guide?

This guide contains a variety of information to help billers submit accurate and timely Medicare claims. While providing historical and background information on Medicare Part A and Medicare Advantage (formerly Medicare + Choice), this guide is focused on providing information and procedures for physicians and suppliers to submit Medicare Part B claims. It is divided into the following sections and contains reference sections at the end of the guide.

Section 1.0 - Introduction to Medicare

Provides an overview of the Medicare Program, describing what it is, who manages and administers the program, eligibility requirements, and coverage requirements.

Section 2.0 - Becoming a Medicare Provider

Provides an introduction to the general rules for participating as a Medicare provider. It explains the types of providers, instructions for enrollment and updating provider information, common enrollment questions and answers, and information regarding reimbursement.

Section 3.0 - Submitting Medicare Claims

Provides an overview of how to submit both an electronic or a paper Medicare claim, how a provider can or cannot accept assignment, how to submit assigned and non-assigned claims, and Medicare Secondary Payer (MSP) submission regulations.

Section 4.0 - Protecting Medicare from Fraud and Abuse

Provides an overview of the Medical Review (MR) process, the Progressive Corrective Action (PCA) process, and ways to identify and prevent Medicare fraud and abuse.

Section 5.0 - Troubleshooting Denials and Claim Rejections

Explains numerous billing and data entry errors and provides methods for a provider to avoid such errors and submit Medicare claims accurately to avoid denied claims.

Section 6.0 - Introduction to HIPAA

Provides an overview of the Health Insurance Portability and Accountability Act (HIPAA) that protects health insurance coverage for workers and their families, establishes national standards for electronic healthcare transactions, and protects security and privacy of health data.

Reference A - Provider Specialty Codes
Contains a list of physician and supplier specialties and their related codes.

Reference B - Form CMS-1500
Contains a template of the Part B claim form submitted to carriers and instructions for completing the form.

Reference C - Form CMS-1500 Electronic Claim Format Item Crosswalk
Contains a crosswalk that matches Form CMS-1500 paper claim items to the corresponding electronic claim fields.

Reference D - Beneficiary Admission Questionnaire
Contains questions that the provider should ask Medicare beneficiaries upon each inpatient and outpatient admission.

Reference E - Place of Service (POS) Codes
Contains a list of POS codes and their related codes used on claims submission forms.

Reference F - Health Care Claim Adjustment Reason Codes
Contains a list of healthcare claim adjustment reason codes used on claims adjustment forms.

Reference G - Remittance Advice (RA) Remark Codes
Contains a list of RA remark codes used on Remittance Notices.

Reference H - Glossary
Contains a list of terms used throughout this document.

Reference I - Acronyms
Contains a list of acronyms used throughout this document.

Reference J - Websites and Phone Numbers
Contains a list of websites and phone numbers that are referenced throughout this document.

The typeface conventions used for the text contained within this document are listed below:

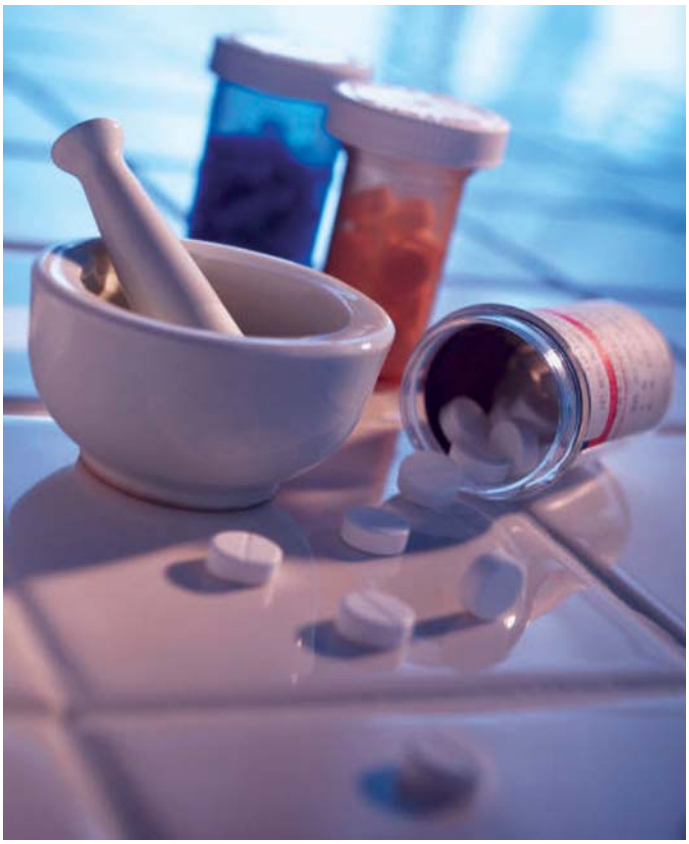
Typeface	Example
Default	This is text in default format.
Italic	*This text is emphasized in italic format.*
bold	**This text is emphasized in bold format.**
bold italic	***This text is emphasized in bold italic format.***
BOLD CAPS	**THIS TEXT IS EMPHASIZED IN BOLD CAPS**
ITALIC CAPS	*THIS TEXT IS EMPHASIZED IN ITALIC CAPS*

Information is organized and presented using the hierarchy of headings that are listed below:

Heading Style	Example
HEADING 1 STYLE	18pt AGaramond Bold, Caps, Centered, Blue
HEADING 2 STYLE	14pt AGaramond, Caps, Centered, Blue (85%)
HEADING 3 STYLE	12pt AGaramond, Bold, Caps, Centered, Blue (75%)
Heading 4 Style	12pt AGaramond, Bold, Centered, Black
Heading 5 Style	12pt AGaramond, Bold, Italics, Centered, Black

Part 1
Introduction to Medicare

The Medicare Program is currently the world's largest health insurance program. When Medicare began on July 1, 1966, approximately 19 million people enrolled. By 2002, over 41 million people were enrolled in one or both parts of the Medicare Program (known as “Original Medicare”), and 5.5 million of them chose to participate in a Medicare Advantage plan (formerly Medicare + Choice). Medicare also establishes guidelines for private insurance plans (known as Medigap) that help pay for deductibles, coinsurance amounts, and other costs (e.g., prescription drugs) not covered by Medicare. Congress has established specific rules regarding how various beneficiary health insurance plans are coordinated so that Medicare payments are issued fairly and equitably.



In addition to the materials presented in this chapter, the following resources are available to provider staff and beneficiaries who need information regarding Medicare:

Provider Resources:

- Access updated information regarding coverage and payment policy, billing, contacts, and Frequently Asked Questions (FAQs) on the Medicare Learning Network at http://www.cms.hhs.gov/MLNGenInfo on the CMS Website.
- Access local policy and claims processing questions from the Medicare payment contractor's website or the toll-free Help Line that was provided during enrollment and is located within the provider newsletter/update.

Beneficiary Resources:

- Access answers to common Medicare questions by calling the toll-free 1-800-MEDICARE (1-800-633-4227) Help Line. TTY users may call 1-877-486-2048.
- Access http://www.medicare.gov on the Web to obtain basic Medicare information and resources such as:
  - Information regarding prescription drugs and other assistance programs;
  - Helpful contacts within the Medicare Program;
  - A dialysis facility comparison tool (to

determine options for saving out-of-pocket expenses);
- A participating physician directory;
- A nursing home comparison tool (to determine options for saving out-of-pocket expenses);
- A supplier directory;
- Publications such as *The Medicare & You 2004* handbook; and
- Beneficiary-focused FAQs.

- Access to a local State Health Insurance Assistance Programs (SHIP) where specially-trained staff and volunteer counselors provide personal health insurance counseling. Services are free, unbiased, and confidential. Local phone numbers are available by calling the toll-free Help Line.

WHAT IS MEDICARE?

Title XVIII of the Social Security Act, designated "Health Insurance for the Aged and Disabled", is more commonly known as Medicare. As part of the Social Security Amendments of 1965, Medicare legislation established a health insurance program for aged persons to complement the retirement, survivor, and disability insurance benefits under Title II of the Social Security Act.

When first implemented in 1966, Medicare covered most persons age 65 or over. In 1973, the following groups also became eligible for Medicare benefits:

- Persons entitled to Social Security or Railroad Retirement disability cash benefits for at least 24 months;
- Most persons with end-stage renal disease (ESRD); and
- Certain otherwise non-covered aged persons who elect to pay a premium for Medicare coverage.

Medicare has traditionally consisted of two parts: Part A and Part B (i.e., Original Medicare). A newer, third part of Medicare, sometimes known as Part C, is the Medicare Advantage Program. This program, formerly known as Medicare + Choice, is available to individuals who qualify for Original Medicare. Medicare Advantage was established by the Balanced Budget Act of 1997 (BBA) (Public law 105-33) and expanded beneficiaries' options for participation in private-sector healthcare plans. This drug coverage, known as Medicare Part D, is provided by private health plans. This coverage can be drug-only or is provided through a Medicare Advantage plan that offers comprehensive benefits.

New Medicare Law and Drug Card Information
Current details about the 2003 Medicare legislation and related policies may be found at: http://www.cms.hhs.gov/MMAupdate on the Web. If your Medicare patients raise questions about the Discount Drug Card, you should suggest that he or she call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-800-486-2048. The patient could also visit http://www.medicare.gov on the Web and select "Prescription Drug and Other Assistance Programs".

On December 8, 2003, the Medicare Modernization Act (MMA) of 2003 was signed into law. This legislation provides seniors and people living with disabilities with a prescription drug benefit, additional choices, and enhanced benefits under Medicare (including new preventive services under Part B). Most notably, this act provides Medicare beneficiaries with opportunities for discounts on their prescription drugs during 2004 and 2005, as well as voluntary comprehensive Medicare prescription drug coverage, effective on January 1, 2006.

UNDERSTANDING THE MEDICARE PART A BENEFIT

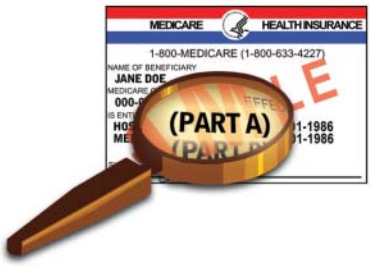
Medicare Part A, referred to as "Hospital Insurance", helps cover services and supplies related to inpatient hospital stays, Skilled Nursing Facility (SNF) care following a related, covered

three-day hospital stay, some home health care, and hospice care for the terminally ill. The Social Security Administration (SSA) will determine if an individual must pay a premium for Medicare Part A, but most beneficiaries do not pay a premium because they (or a spouse) paid Medicare taxes while they were working.

A provider can determine if a beneficiary has Part A benefits by looking at the beneficiary's red, white, and blue Medicare identification card (see Figure 1-1). *Earlier versions of this card may appear differently than the card shown below, however, these earlier versions are still valid.*

Figure 1-1. Medicare Identification Card

If the beneficiary's Medicare card says "Hospital (Part A)", he or she is entitled to Part A benefits.



If a patient qualifies for inpatient hospital care, services covered by Medicare Part A include the following:

- A semiprivate room;
- Meals;
- Blood transfusions;
- General nursing;
- Medications administered during the inpatient stay;
- Special care units, such as intensive or coronary care; and
- Other hospital services and supplies.

This includes care in critical access hospitals (CAHs) and inpatient mental health care in an independent psychiatric facility. Coverage does **NOT** include private-duty nursing, an in-room television or telephone, or a private room (unless a private room is deemed medically necessary).

If a patient qualifies for SNF care, services covered by Medicare Part A include the following:

- A semiprivate room;
- Meals;
- Blood transfusions;
- Skilled nursing and rehabilitative services;
- Medical social services;
- Medications and medical supplies and equipment used in the facility;
- Ambulance transportation (when other transportation would endanger health) to the nearest provider of needed services not available at the SNF;
- Dietary counseling; and
- Other services that SNFs generally furnish such as laboratory tests and X-rays.

To be eligible for home health care, a beneficiary must meet the following four conditions:

- A doctor must decide that the beneficiary needs medical care in his or her home and must create a plan for home health care for that beneficiary;
- The beneficiary must need at least one of the following:
  - Intermittent (and not full-time) skilled nursing care;
  - Physical therapy;
  - Speech/language therapy services; or
  - Continuing occupational therapy.
- The beneficiary must be homebound (unable to leave home or leaving home is a major effort). If the patient does leave the house, he or she may continue to be considered homebound if the absences are infrequent or for periods of short duration, or are to receive healthcare treatment. This may include regular absences to participate in therapeutic, psychological, or medical

treatment in an adult day-care program that is approved by the state. Any other absence of an individual from the home may be permitted if the absence is infrequent or of short duration; and

- The home health agency (HHA) that provides the care must be Medicare-approved.

Occupational Therapy at Home Services provided by an occupational therapist (OT) under the home health benefit must be started by another discipline (e.g., intermittent skilled nursing, physical therapy, speech language pathology). Once established, OT becomes a qualifying discipline and may remain in the home as long as OT services are required and the patient meets all the eligibility criteria.

If a beneficiary qualifies for home health care, the following services are covered by Medicare Part A for each 60-day episode of care:

- Part-time skilled nursing care;
- Physical therapy;
- Occupational therapy;
- Speech/language pathology therapy;
- Home health aide services;
- Medical supplies such as wound dressings (but NOT prescription drugs);
- Durable Medical Equipment (DME) such as wheelchairs, hospital beds, oxygen, and walkers; and
- Medical social services.

If a beneficiary qualifies for hospice care, the following services are covered by Medicare Part A in "periods of care" (i.e., two 90-day periods followed by 60-day periods as needed):

- Doctor services;
- Nursing care;
- Physical therapy;
- Occupational therapy;
- Speech therapy;
- DME;
- Medical supplies such as bandages and catheters;
- Drugs for symptom control and pain relief;
- Short-term hospital and inpatient respite care;
- Home health aide and homemaker services;
- Dietary counseling;
- Counseling to help the beneficiary and their family deal with grief and loss;
- Medical social services; and
- Other services not otherwise covered by Medicare.

Hospice services must be provided by a Medicare-approved hospice, and are usually provided in the patient's home. However, short-term hospital and inpatient respite care (care given to a hospice patient so that the usual caregiver can rest) are covered when needed.

UNDERSTANDING THE MEDICARE PART B BENEFIT

Medicare Part B, referred to as "Medical Insurance", helps cover doctors' services, certain medical items, and outpatient care. Part B also covers medical services such as physical therapy and some home health care furnished by hospitals, SNFs, and other institutional providers, when the beneficiary does not qualify for Part A benefits.

A provider can determine if a beneficiary has Part B benefits by looking at the beneficiary's red, white, and blue Medicare card (see Figure 1-1).

If the beneficiary's Medicare card says "Medical (Part B)", he or she is entitled to Part B benefits.

The following services and supplies are covered under Part B, when medically necessary:

- Medical services;
- Clinical laboratory services;

- Some home health care;
- Outpatient hospital services;
- Blood transfusions (after the first three pints);
- Some preventive services;
- Ambulance services (when other transportation would endanger health); and
- Medical social services.

Part B Coverage and Payment Criteria
Providers who submit Part B claims should always refer to their carrier's Local Medical Review Policies (LMRPs) and other billing guidance for specific coverage and payment criteria.

Part B requires payment of a monthly premium that is usually taken out of the beneficiary's Social Security, Railroad Retirement, or Office of Personnel Management Retirement payment. If the beneficiary does not receive one of these payments, Medicare will bill for the premium every three months. In addition to the premium, the beneficiary must meet an annual deductible and pay all coinsurance amounts unless he or she has other supplemental insurance.

If a beneficiary is entitled to Medicare Part B, covered services for medical care and other services include:

- Doctors' services;
- Outpatient medical and surgical services and supplies;
- Diagnostic examinations and tests;
- Ambulatory surgery center facility fees for approved procedures;
- DME such as wheelchairs, hospital beds, oxygen, and walkers;
- Second surgical opinions;
- Outpatient mental health care; and
- Outpatient physical and occupational therapy, including speech/language therapy.

If a beneficiary is entitled to Medicare, the covered services for clinical laboratory services include the following:

- Blood tests;
- Urinalysis; and
- Other tests requested by a provider.

If a beneficiary is entitled to Medicare, the covered services for home health care include the following:

- Part-time skilled nursing care;
- Physical therapy;
- Occupational therapy;
- Speech/language therapy;
- Home health aide services;
- Medical social services;
- DME such as wheelchairs, hospital beds, oxygen, and walkers; and
- Medical supplies and other services.

Part B helps cover hospital services and supplies that a beneficiary receives as an outpatient when under a doctor's care. Part B also covers blood transfusions that a beneficiary may receive as an outpatient, or as part of a service covered under Part B.

Medicare Part B also helps to cover:

- Ambulance services when other transportation would endanger the patient's health;
- Artificial eyes;
- Artificial limbs that are prosthetic devices, and their replacement parts;
- Braces - arm, leg, back, and neck;
- Chiropractic services (limited), for manipulation of the spine to correct a subluxation;
- Emergency care;
- Eyeglasses - one pair of standard frames after each cataract surgery with an intraocular lens;
- Immunosuppressive drug therapy for transplant patients if the transplant was paid for by Medicare, or paid by private insurance that paid as a primary payer to Medicare Part A coverage, in a Medicare-certified facility;
- Kidney dialysis;
- Medical Nutrition Therapy (MNT) services for people who have diabetes or kidney

disease (unless currently on dialysis) with a doctor's referral. The MNT services will be covered for three years after the kidney transplant;
- Medical supplies - items such as ostomy bags, surgical dressings, splints, casts, and some diabetic supplies;
- Very limited outpatient prescription drugs (e.g., some oral drugs for cancer);
- Preventive services:
  - Bone mass measurements;
  - Colorectal cancer screening by colonoscopy;
  - Diabetes services and supplies;
  - Glaucoma screening;
  - Mammography screening;
  - Papanicolaou (Pap) test and pelvic examination (includes a clinical breast exam);
  - Prostate cancer screening by digital rectal examination (DRE); and
  - Shots (vaccinations).
- Prosthetic devices, including breast prosthesis after mastectomy;
- Second surgical opinion by a doctor (in some cases);
- Services of practitioners such as clinical social workers, physician assistants (PAs), and nurse practitioners;
- Telemedicine services in some rural areas;
- Therapeutic shoes for people with diabetes (in some cases);
- Transplants - heart, lung, kidney, pancreas, intestine, bone marrow, cornea, and liver (under certain conditions and when performed at Medicare-certified facilities); and
- X-rays, MRIs, CT scans, EKGs, and some other purchased diagnostic tests.

UNDERSTANDING THE MEDICARE ADVANTAGE (FORMERLY MEDICARE + CHOICE) PLAN

The Medicare Advantage Program was established by the Balanced Budget Act of 1997 (BBA). The program is a set of healthcare options created by the BBA to provide care under contract to Medicare, to possibly reduce beneficiaries' out-of-pocket expenses, and offer beneficiaries more health care and contractor choices. Beneficiaries who qualify for Original Medicare benefits (Part A and Part B) have the option to be covered under a Medicare Advantage plan if one is available in their area instead of Original Medicare.

Medicare Advantage
Since MMA was signed into law in 2003, the Medicare Advantage program will undergo some significant changes. Effective March 1, 2004, increased payments will go into effect to Medicare Advantage (formerly Medicare + Choice). Additional information regarding MMA is available at http://www.cms.hhs.gov/MMAupdate on the Web. The new 2004 Medicare Advantage payment rates are available at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats on the Web.

To participate in Medicare, a Medicare Advantage plan must have a contract with the Secretary of The Department of Health and Human Services (DHHS). It must provide the same services a beneficiary would be eligible to receive from Medicare if he or she were in Original Medicare. In other words, the beneficiary is still technically "on Medicare", but has selected a different contractor and is required to receive services according to that contractor's arrangements.

Medicare Advantage plans may include the following:

- Medicare managed care plan;
- Medicare managed care plan with a Point of Service (POS) option;
- Provider Sponsored Organization (PSO);
- Preferred Provider Organization (PPO);
- Medical Savings Account (MSA);
- Private fee-for-service plan; or
- Religious fraternal benefit society plan.

The Medicare Advantage Program places special limitations and requirements on beneficiaries with

ESRD. Persons entitled to Medicare because they have ESRD are limited to the Original Medicare Plan, except in special circumstances. A beneficiary with ESRD cannot join a Medicare Advantage plan; however, if he or she developed ESRD while previously enrolled, he or she can remain enrolled. He or she may also join a different plan offered by the same company in the same state.

If a beneficiary who has ESRD is enrolled in a Medicare Advantage plan and the plan stops offering service in the beneficiary's service area, he or she may join another Medicare Advantage plan if one is available. This regulation applies to anyone whose plan left the Medicare Advantage plan after December 31, 1998.

If a beneficiary leaves a Medicare Advantage plan for other reasons after developing ESRD, he or she can only choose the Original Medicare Plan.

Persons who have had a successful kidney transplant and no longer require regular dialysis are not considered to have ESRD. This means that the beneficiary is eligible to join a Medicare Advantage plan as long as he or she has met all other eligibility requirements.

PROVIDING SERVICES TO PATIENTS ENROLLED IN MEDICARE ADVANTAGE PLANS

Physicians and suppliers and their billing personnel must be aware that Medicare Advantage plans do not operate under the same coverage and payment policy for claims processing as Original Medicare. ***If a beneficiary is a member of a Medicare Advantage plan, the local Part B carrier cannot process claims for that beneficiary.***

When a physician or supplier submits claims for a beneficiary enrolled in a Medicare Advantage plan, the local Medicare Part B carrier will deny payment (except dialysis and related services provided in a dialysis facility). After denial, the carrier will automatically transfer the claim to the appropriate Medicare Advantage plan.

However, a Medicare managed care plan is **NOT** responsible for paying Medicare Advantage claims, **EXCEPT** under the following situations:

- The physician or supplier is affiliated with the Medicare Advantage plan; or
- The physician or supplier furnishes emergency services, urgently needed services, or other covered services not reasonably available through the Medicare Advantage plan.

FILING CLAIMS WITH A MEDICARE ADVANTAGE PLAN

A provider may be reimbursed when filing a claim to a Medicare Advantage plan if they are an in-network provider, or an out-of-network provider that furnished services that are identified in the second bullet of Part I, Providing Services to Patients Enrolled in Medicare Advantage Plans. However, if the plan denies the claim, the provider has the right to appeal the claim to the plan or CMS. An out-of-plan provider may also collect the full fee for services rendered from the patient if the patient did not receive prior authorization to see the out-of-plan provider.

PROVIDERS WHO ARE NOT MEDICARE ADVANTAGE PROVIDERS

BEFORE rendering service, providers who are affiliated with a Medicare Advantage plan should emphasize to their patient what their financial liability will be if the patient did not receive prior authorization to see the out-of-plan provider. If the patient chooses to see a provider not affiliated with their Medicare Advantage plan for healthcare services, he or she should clearly understand that he or she may be responsible for the full fee for services rendered.

WHAT IS MEDICAID?

Title XIX of the Social Security Act is a Federal/State entitlement program that pays for medical assistance for certain individuals and families with low incomes and resources. This program, known as Medicaid, became law in

1965 as a cooperative venture jointly funded by the Federal and State governments (including the District of Columbia and the Territories) to assist states in furnishing medical assistance to eligible needy persons. Medicaid is the largest source of funding for medical and health-related services for America's poorest individuals. Within broad national guidelines established by Federal statutes, regulations, and policies, each state:

- Establishes its own eligibility standards;
- Determines the type, amount, duration, and scope of services;
- Sets the rate of payment for services; and
- Administers its own program.

Medicaid policies for eligibility, services, and payment are complex and vary considerably, even among states of similar size or geographic proximity. Thus, a person who is eligible for Medicaid in one state may not be eligible in another state, and the services provided by one state may differ considerably in amount, duration, or scope from services provided in a similar or neighboring state. In addition, Medicaid eligibility and/or services within a state can change during the year.

THE MEDICARE-MEDICAID RELATIONSHIP

Medicare beneficiaries who have low incomes and limited resources may also receive help from the Medicaid Program. For persons who are eligible for full Medicaid coverage, the Medicare healthcare coverage is supplemented by services that are available under their state's Medicaid Program, according to eligibility category. These additional services may include nursing facility care beyond the 100-day limit covered by Medicare, prescription drugs, eyeglasses, and hearing aids. **For persons enrolled in both programs, any services that are covered by Medicare are paid for by the Medicare Program before any payments are made by the Medicaid Program, since Medicaid is always the "payer of last resort".**

Certain other Medicare beneficiaries may receive help with Medicare premium and cost-sharing payments through their State Medicaid Program. Qualified Medicare Beneficiaries (QMBs) and Specified Low-Income Medicare Beneficiaries (SLMBs) are the two best-known and largest categories of these types of beneficiaries. For QMBs, Medicaid pays the Medicare Part A and Medicare Part B premiums and the Medicare coinsurance amounts and deductibles, subject to limits that states may impose on payment rates. For SLMBs, the Medicaid Program pays only the Medicare Part B premiums.

A third category of Medicare beneficiaries who may receive help consists of disabled-and-working individuals. According to Medicare law, disabled-and-working individuals who previously qualified for Medicare because of disability, but who lost entitlement because of their return to work (despite the disability), are allowed to purchase Medicare Part A and Medicare Part B coverage. If these persons meet certain requirements, they may qualify to have Medicaid

pay their Medicare Part A premiums as Qualified Disabled and Working Individuals (QDWIs). According to CMS estimates, Medicaid currently provides some level of supplemental health coverage for 5 million Medicare beneficiaries within the above three categories.

States vary in their participation in these programs for people with limited income and resources that help pay Medicare premiums. Some programs also pay Medicare deductibles and coinsurance.

Availablity of "Medicare Savings" Programs
Providers may recommend that low-income patients call 1-800-MEDICARE (1-800-633-4227) to see if such "Medicare Savings" programs are available locally. TTY users should call 1-877-486-2048.

HOW IS MEDICARE ADMINISTERED?

As a Federal health insurance benefit program, Medicare represents the cooperative efforts and organization of numerous government and non-governmental organizations. The following section identifies the major organizations that impact Medicare.

CONGRESS

Congress passes laws that affect Medicare reimbursement of providers and beneficiaries.

SOCIAL SECURITY ADMINISTRATION (SSA)

The SSA, an independent agency, has special responsibilities in five major benefit areas: retirement, disability, family benefits, survivors, and Medicare. The SSA assures that beneficiaries are eligible for Medicare benefits and enrolls them in Parts A and/or B, the Federal Black Lung Program (also referred to as the Funds), or Medicare Advantage (formerly Medicare + Choice). When a patient enrolls in Medicare, CMS issues an initial enrollment package and a Medicare identification card.

The SSA is also responsible for the following:

- Maintaining deductible status;
- Requesting replacements for lost or stolen Medicare cards;
- Updating address changes;
- Maintaining and establishing beneficiary enrollment;
- Collecting premiums from beneficiaries who receive retirement or disability benefits; and
- Educating beneficiaries regarding coverage and insurance choices.

DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS)

DHHS is the U.S. Cabinet-level department that oversees Federal health programs, including Medicare, and provides essential human services. The Secretary of DHHS contracts with private insurance companies to process Medicare claims. DHHS is responsible for conducting fraud and abuse audits and investigations for the Federal Government.

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

CMS, an agency of DHHS, administers Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP) by creating coverage and payment policies according to Congressional mandates. CMS also regulates laboratory testing and the survey and certification of healthcare facilities, including nursing homes, HHAs, intermediate care facilities for the mentally handicapped, and hospitals.

WHERE IS CMS LOCATED?

The CMS Central Office is located in Baltimore, Maryland. The following ten Regional Offices (ROs), shown with their associated region codes, provide policy guidance to several Medicare payment contractors:

- Atlanta [04];
- Boston [01];
- Chicago [05];
- Dallas [06];
- Denver [08];
- Kansas City [07];
- New York [02];
- Philadelphia [03];
- San Francisco [09]; and
- Seattle [10].

Figure 1-2 shows how each CMS region is defined by state and/or territory.

WHAT ARE FISCAL INTERMEDIARIES (FIS) AND CARRIERS?

Medicare's Part A and Part B fee-for-service claims are processed by non-governmental organizations or agencies that contract to serve as the fiscal agent between providers and suppliers and the Federal Government. These claims processors are known as *FIs* and *carriers*. These contractors apply the Medicare coverage rules to determine the appropriateness of claims.

Medicare FIs process Part A claims for institutional services, including inpatient hospital claims, SNFs, HHAs, and hospice services. FIs also process Part B claims submitted by institutional providers, including hospital outpatient services. Examples of FIs include the Blue Cross Blue Shield Association (BCBSA), which utilizes its plans in various states, and other commercial insurance companies. An FI's responsibilities include the following:

Figure 1-2. Map of Regions by State and/or Territory

RO Contact Information
To access contact information for each RO, please visit the CMS ROs at http://www.cms.hhs.gov/about/regions/professionals.asp on the Web.

- Determining costs and reimbursement amounts;
- Maintaining records;
- Establishing controls;
- Safeguarding against fraud and abuse or excess use;
- Conducting reviews and audits;
- Making payments to providers for services; and
- Assisting both providers and beneficiaries as needed.

Medicare carriers handle Part B claims for services by physicians and medical suppliers. Examples of carriers are the BCBSA plans in a state, and various commercial insurance companies. Carriers' responsibilities include the following:

- Determining charges allowed by Medicare;
- Maintaining quality-of-performance records;
- Assisting in fraud and abuse investigations;
- Assisting physicians, suppliers, and beneficiaries as needed; and
- Making payments to physicians and suppliers for services that are covered under the Part B benefit.

Physicians and suppliers that have claims processed by carriers are considered Part B providers. Carriers may only process Part B claims. Conversely, institutional providers that have claims processed by FIs are considered Part A providers. This situation sometimes creates confusion since FIs process Medicare claims for both Part A and Part B benefits. When a provider is called a Part A provider, it simply means that the provider has claims processed by an FI. For example, an outpatient rehabilitation facility (commonly known as a rehabilitation agency) can only bill for Part B services, but since it submits claims to an FI, it is considered a Part A provider.

Submitting Claims to FIs
Providers who submit claims to FIs should always refer to their FI's Local Medical Review Policies (LMRPs) and other billing guidance for specific coverage and payment criteria.

Part B providers (physicians and suppliers) can only bill for services under the Part B benefit (see Figure 1-3). Part A providers can bill for services under the Part A benefit, the Part B benefit, or both.

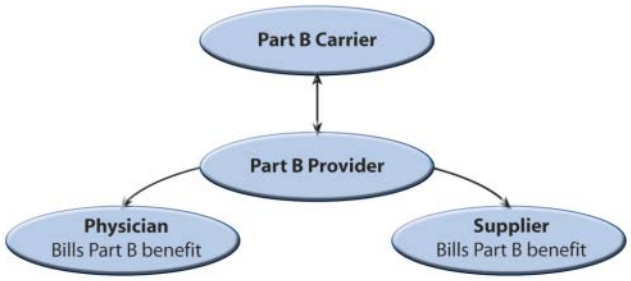


Figure 1-3. Part B Benefit

WHO ARE MEDICARE BENEFICIARIES?

Medicare Part A eligibility is based on one's earnings, or on the earnings of a spouse, parent, or child. A specified number of "quarters of coverage" (QCs) must be earned through payment of payroll taxes. The exact number of QCs required for insured status depends on the basic group to which the individual belongs. If an individual has paid taxes for 40 QCs, he or she is

Directory of FIs and Carriers
To view a current directory of FIs and carriers, please visit the Intermediary-Carrier Directory at http://www.cms.hhs.gov/apps/contacts/incardir.asp on the Web.

eligible for “premium-free” Part A. Those who work for shorter periods would need to pay premiums depending on the length of taxpaying employment.

The three basic types of individuals eligible for Medicare insurance include:

- The aged;
- The disabled; and
- Those with ESRD.

Medicare Part B is a voluntary program for which the insured pays a monthly premium. All individuals who are entitled to premium-free Part A are eligible to enroll in Part B. Individuals who are not eligible for premium-free Part A can enroll in Part B if they are:

- Age 65;
- A resident of the U.S.; and
- A U.S. citizen or an alien lawfully admitted for permanent residence who has continuously resided in the U.S. for the five-year period immediately preceding the month he or she files for Part B.

The cost of this premium is normally deducted from Social Security checks automatically and represents 25% of the cost of coverage. The remainder is financed from general tax revenues.

As described earlier, an individual eligible for Original Medicare (Part A and Part B) has the option to enroll in a Medicare Advantage plan at any time. Since the enrollee has options to enroll in Part B or Medicare Advantage at different times than when he or she enrolled in Part A, the effective dates on his or her Medicare cards may vary, depending on the month/year in which enrollment takes place.

As described in Part I, The Medicare-Medicaid Relationship, certain low-income individuals may also qualify through Medicare Savings Programs. Many states have such programs for people with limited income and resources that pay Medicare premiums when individuals do not qualify for Medicaid. Some programs may also pay Medicare deductibles and coinsurance amounts.

The following section details the minimum criteria people must meet to enroll in the Medicare Program as an aged insured, disabled insured, or ESRD insured beneficiary.

AGED INSURED

An “aged insured” person is age 65 years old or older and eligible for monthly Social Security or Railroad Retirement cash benefits, or equivalent Federal benefits. Medicare enrollment typically occurs simultaneously upon application for Social Security benefits. Therefore individuals that receive SSA benefits “early” will be automatically enrolled in Medicare Part A the month they turn age 65.

Medicare Eligibilty and Enrollment Information
Questions about Medicare eligibility and enrollment should be referred to the beneficiary's local Social Security Field Office or the SSA's toll-free number at 1-800-772-1213. TTY users should call 1-800-325-0778.

Medicare Part B is voluntary and becomes effective based on the enrollment period in which the individual enrolls. The earliest an individual may enroll in Part B is three months before a person turns age 65 and ends three months later. If a beneficiary chooses *not* to enroll in Medicare Part B during the initial enrollment period, he or she may enroll during other specified times. However, the cost of Part B may go up 10% for each 12-month period the beneficiary was eligible for Part B, except in special cases. The beneficiary will have to pay this extra amount for the rest of his or her life.

DISABLED INSURED

An insured person entitled to Social Security, Railroad Retirement, or equivalent Federal benefits, based on disability, is automatically entitled to Part A hospital insurance and is

considered enrolled for Part B unless coverage was refused. This type of entitlement is also available to a disabled widow or widower, or the disabled child of a deceased, disabled, or retired worker. Generally, entitlement begins after the individual has been entitled to receive benefits for 24 months, not the date he or she became disabled. However, individuals whose disability is Amyotrophic Lateral Sclerosis (ALS) do not have to wait 24 months for Medicare. These beneficiaries are entitled to Medicare the first month they are entitled to disability benefits.

If it is determined that an individual is no longer disabled, a notification of disability termination is sent, and Medicare Part A and Part B entitlement ends the following month.

END-STAGE RENAL DISEASE (ESRD) INSURED

Individuals of any age who require regular dialysis or a kidney transplant are eligible for Medicare if they:

- Worked the required amount of time under Social Security, the Railroad Retirement Board (RRB), or as a government employee; or
- Are receiving, or are eligible to receive, Social Security or Railroad Retirement benefits; or
- Are the spouses or dependent children of such insured or entitled persons.

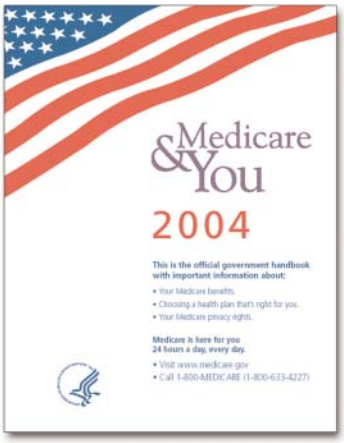
Entitlement to Medicare usually begins after a three-month waiting period (e.g., the first day of the third month after the course of renal dialysis begins). Entitlement can begin at an earlier date, if certain requirements are met.

Medicare is the secondary payer for claims during the 30-month coordination period for ESRD beneficiaries who are covered by a Group Health Plan (GHP). This 30-month coordination period begins with the first day of Medicare eligibility. The exception is an aged or disabled beneficiary who had GHP coverage that was secondary to Medicare when ESRD occurred.

For patients eligible for Medicare solely based on ESRD, coverage ends on the earliest of the following dates:

- The patient's date of death;
- The last day of the 12th month after the month the course of dialysis is discontinued, unless the patient receives a kidney transplant during that period or begins another course of dialysis; or
- The last day of the 36th month after a person receives a kidney transplant. If the transplant fails and a regular course of dialysis is initiated or another transplant is performed within the 36 months, entitlement continues. If a patient whose entitlement based on ESRD has ended begins a new course of dialysis or has a kidney transplant, re-entitlement begins without a waiting period.

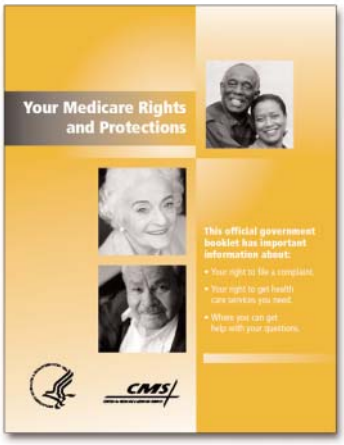
WHAT ARE MEDICARE BENEFICIARY RIGHTS?



Provider staff should be familiar with the Medicare beneficiary rights that apply to the type of services they furnish and the type of Medicare insurance plan for which they are submitting claims. The Medicare beneficiary handbook, *Medicare & You 2004*, is published by CMS and sent to all Medicare beneficiaries. The handbook discusses the guaranteed rights of Medicare beneficiaries, which include the following:

- Protection when they get healthcare services;
- Assured access to needed healthcare services;
- Protection against unethical practices;
- The right to receive emergency care without prior approval;

- The right to appeal the Original Medicare Plan's decision about payment/services provided;
- The right to information about all treatment options;
- The right to know how their Medicare health plan pays its doctors; and
- The right of the beneficiary to submit a written request to a physician or supplier for an itemized statement for any Medicare item or service received. The physician or supplier must furnish the itemized statement within 30 days of the request. Failure to provide the statement on time can result in a civil monetary penalty of up to $100.00 for each failure.



CMS has also developed an additional publication, *Your Medicare Rights and Protections*, that provides details about beneficiary rights that are specific to Original Medicare, Medicare Managed Care Plans, and Medicare Private Fee-for-Service Plans.

Beneficiary Rights Information
To view publications and many other helpful documents regarding beneficiary rights, please visit http://www.medicare.gov on the Web.

HOW DOES A PROVIDER IDENTIFY A QUALIFIED MEDICARE BENEFICIARY?

When an individual becomes entitled to Medicare, he or she receives a health insurance card. This card contains important information that must be included on all claims submitted by providers:

- Name;
- Sex;
- Health Insurance Claim Number (HICN);
- Effective date of entitlement to Part A insurance; and
- Effective date of entitlement to Part B insurance.

Most Medicare beneficiaries receive health insurance cards issued by the SSA; however, the RRB issues a Medicare card to individuals eligible for Medicare Railroad Retirement benefits.

Billing Without a Medicare Card
Providers may bill Medicare without a copy of the patient's Medicare card but they should confirm that the patient has coverage prior to billing.

CMS-ISSUED MEDICARE NUMBERS

Medicare numbers issued by CMS typically reflect the Social Security Number (SSN) of either the insured or a spouse (possible divorced or deceased) depending on the wage earner upon whose earnings eligibility is based.

RRB-ISSUED MEDICARE NUMBERS

Medicare numbers issued by the RRB may be the insured's SSN or a six-digit number (zeros may be added at the beginning to bring it to nine digits). Regardless of the length of the number, the insured's number will always have an alpha *prefix* (with one or more characters). For example, H000-000 or H000-000-000 would be a railroad pensioner (age or disability).

Accuracy of Beneficiary Information is Important
*Failure to record the beneficiary's name and identification number on a claim **exactly** as they appear on the Medicare card may result in a payment denial or claim delay.*

Patient Identification
Due to an increase in lost and stolen Medicare cards, checking and copying a patient's picture identification is suggested to ensure that the patient is eligible to receive benefits. *If Medicare has paid a claim for services rendered to a non-Medicare-eligible beneficiary, a refund request may be generated.*

VERIFYING BENEFICIARY ELIGIBILITY

Social Security benefits are the basis for eligibility for most Medicare patients. The eligibility source can be determined by asking to see the patient's Medicare card. Maintaining a photocopy of the card in the patient's file may prevent errors. The provider's office should develop a process to regularly verify Medicare insurance information and update patients' records to reflect current information.

WHAT IS MEDIGAP?

A Medigap policy is a health insurance policy sold by private insurance companies to fill “gaps” in the Original Medicare Plan coverage. Medigap policies must follow Federal and State laws that protect the beneficiary. The front of the Medigap policy must clearly identify it as “Medicare Supplemental Insurance”. In all states except Massachusetts, Minnesota, and Wisconsin, a Medigap policy must be one of ten standardized policies that can be compared easily. Each policy has a different set of benefits. Two of the standardized policies may have a high deductible option. In addition, any standardized policy may be sold as a “Medicare SELECT” policy.

Updated MMA Information
Updated information may be obtained using the Medicare Personal Plan Finder Tool available at http://www.medicare.gov/Help/mppf.asp on the Web.

Medicare SELECT policies usually cost less because the beneficiary must use specific hospitals and, in some cases, specific doctors to get full insurance benefits from the policy. In an emergency, patients may use any doctor or hospital. Certain changes to Medigap policies will occur with the implementation of the MMA.

HOW DO THE COORDINATION OF BENEFITS (COB) AND MEDICARE SECONDARY PAYER (MSP) PROGRAMS WORK?

The MSP Program precludes Medicare from making primary claims payment when a beneficiary has other insurance that should pay first. For example, if a Medicare beneficiary is covered by a GHP as a result of his or her own or his or her spouses' current employment, charges for medical services must first be submitted to his or her GHP for payment.

MSP REGULATIONS

Until 1980, the Medicare Program was the primary payer in all situations except those involving Workers' Compensation (WC) (including the Federal Federal Black Lung Program) benefits. Since 1980, changes in the Medicare law have resulted in Medicare being the secondary payer in other situations. The MSP Program protects Medicare funds and ensures that Medicare does not pay for services reimbursable under private insurance plans or other government programs. Medicare may not

pay if payment has been made, or can be reasonably expected to be made, with respect to an item or service that is covered under other health insurance or coverage.

MEDICARE COORDINATION OF BENEFITS (COB)

The purpose of the COB Program is to identify healthcare coverage that beneficiaries may have that pays primary to Medicare and to coordinate the payment process to prevent mistaken Medicare primary payments. CMS awarded a contract in November 1999, referred to as the Medicare COB contract, to consolidate activities that support the collection, management, and reporting of other insurance coverage that Medicare beneficiaries have. This is one of many initiatives under the Medicare Integrity Program designed to further expand CMS' campaign against Medicare waste, fraud, and abuse. Please see Part 3, Submitting Medicare Secondary Payer (MSP) Claims, for more information regarding submission of MSP claims.

Part 2
Becoming a Medicare Provider

This section introduces billers to the general rules for becoming a Medicare Part B provider, as either a physician or supplier. Although the clinical decisions of what services a patient may need or receive in your setting is the responsibility of the treating physicians and other non-physician healthcare providers, the billing personnel of any provider's office are the principal point of contact between the patient, the treating clinician, and the Medicare claims processing contractor. In this capacity, the provider's billing personnel must be aware of the many rules and regulations that apply to the setting for which they are submitting claims, as well as the limiting charge placed on services billed on a nonassigned claim. This section discusses the various types of Part B providers under Medicare, the general rules and processes with which individuals and groups/clinics must comply in order to enroll as a Medicare Part B provider, and the various Medicare reimbursement systems that affect physicians and suppliers.

WHAT ARE THE TYPES OF MEDICARE PROVIDERS?

The Medicare Program recognizes a broad range of types of facilities and individual providers and suppliers to furnish the necessary services and supplies to meet the healthcare needs of its beneficiaries. As discussed in Part 1, Introduction to Medicare, Part B physicians and suppliers furnish services and supplies that are only paid through the Medicare Part B benefit, and submit claims to carriers or Durable Medical Equipment Regional Carriers (DMERCs). Part B providers include:

- Physicians;
- Nurse practitioners;
- Clinical psychologists;
- Physical therapists in private practice;
- Ambulance service suppliers;
- Independent diagnostic testing facilities;
- Suppliers of Durable Medical Equipment (DME), prosthetics, orthotics, or other medical supplies; and
- Other non-physician providers.

ENROLLING AS A MEDICARE PROVIDER (OR UPDATING ENROLLMENT STATUS)

Physicians wishing to receive payment for Medicare services must complete and submit the appropriate Form CMS-855 provider/supplier enrollment application to the Centers for Medicare & Medicaid Services (CMS). This form requests general information and documentation to ensure that a provider is qualified and eligible to enroll in the Medicare Program. The completed Form CMS-855 and documentation are sent to the appropriate provider enrollment department. The enrollment department verifies the information and documentation, and then the state agency will approve the application.

If the state agency approves the application, the enrollment department will notify the applicant. Notification includes the provider's unique Medicare billing number that is used in all communication with the payment contractor. Table 2-1 contains a list of the agencies that the various types of physicians and suppliers must contact to enroll as a Medicare provider, or to update provider status. In addition, the table indicates whether Medicare requires an on-site survey/certification process for that type of setting.

State Requirements for Provider Type Certification
States may have additional requirements for certification as a certain provider type. Additional information regarding state certification requirements can be accessed at www.cms.hhs.gov/MedicareProviderSupEnroll on the Web.

GENERAL ENROLLMENT PROCESS

Medicare has different enrollment processes depending upon the type of provider submitting the application.

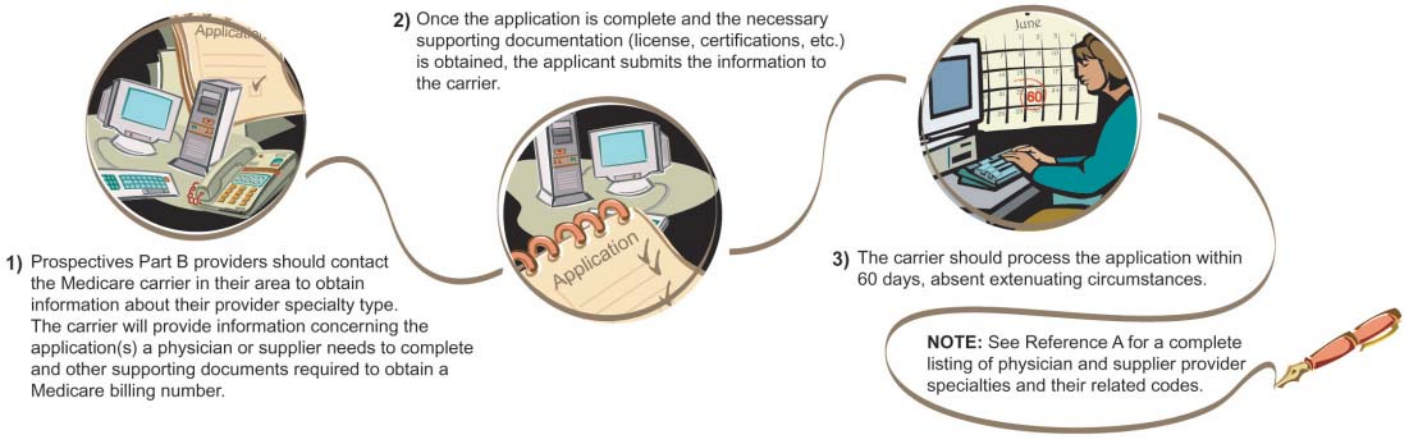
Table 2-1. Provider Enrollment Contacts and Survey Requirements

Provider Type	Contact for Enrollment	Enrollment Form	Contact for Survey/ Certification	On-Site Survey
Ambulance Service Supplier	Carrier	To be determined by carrier (TBD)	Not Applicable (N/A)	N/A
Ambulatory Surgical Center (ASC)	Carrier	CMS-855B	State Agency	Accredited by CMS-approved organization, or surveyed by State Agency
Audiologist	Carrier	TBD	N/A	N/A
Certified Clinical Nurse Specialist	Carrier	TBD	N/A	N/A
Certified Nurse Midwife	Carrier	TBD	N/A	N/A
Certified Registered Nurse Anesthetist	Carrier	TBD	N/A	N/A
Clinic/Group Practice	Carrier	TBD	N/A	N/A

Provider Type	Contact for Enrollment	Enrollment Form	Contact for Survey/ Certification	On-Site Survey
Clinical Psychologist	Carrier	TBD	N/A	N/A
Durable Medical Equipment (DME), Prosthetics, Orthotics, or Supplies	National Supplier Clearinghouse (NSC)	CMS-855A CMS-855B for practitioner services	State Agency for CMS-855A	State Agency CMS-855A
Hospital	Fiscal Intermediary (FI) Also carrier if billing practitioner services	CMS-855A CMS-855B for practitioner services	State Agency for CMS-855A	State Agency CMS-855A
Hospital Department Billing for Part B Practitioner Services	Carrier	CMS-855B	N/A	N/A
Independent Clinical Laboratory	Carrier	CMS-855B	State Agency	State Determines
Independent Diagnostic Testing Facility	Carrier	CMS-855B	N/A	N/A
Indian Health Services Facility	Part A providers - CMS Regional Office (RO) Part B Providers - carriers (TrailBlazer)	TBD by carrier OR RO	Part A Providers - State Agency	Part A Providers State Determines
Mammography Screening Center	Carrier	TBD	N/A	N/A
Managed Care Organization	Carrier	TBD	N/A	N/A
Mass Immunization Roster Biller	Carrier	TBD	N/A	N/A
Medical Faculty Practice Plan	Carrier	TBD	N/A	N/A
Multi-Specialty Clinic or Group Practice	Carrier	TBD	N/A	N/A

Provider Type	Contact for Enrollment	Enrollment Form	Contact for Survey/ Certification	On-Site Survey
Nurse Practitioner	Carrier	TBD	N/A	N/A
Occupational Therapist in Private Practice	Carrier	TBD	N/A	N/A
Occupational Therapy (OT) (Group)	Carrier	TBD	N/A	N/A
Other Medical Care Group	Carrier	TBD	N/A	N/A
Pharmacies	NSC	TBD	N/A	N/A
Physical Therapist in Private Practice	Carrier	TBD	N/A	N/A
Physical Therapy (PT) (Group)	Carrier	TBD	N/A	N/A
Physiotherapy	Carrier	TBD	N/A	N/A
Physician's Assistant (PA)	Carrier	TBD	N/A	N/A
Physician	Carrier	TBD	N/A	N/A
Portable X-ray Facility	Carrier	CMS-855B	State Agency	State Agency
Psychiatric Unit (of a Hospital)	FI Also carrier if billing practitioner services	CMS-855A CMS-855B for practitioner services	State Agency for CMS-855A	State Agency for CMS-855A
Registered Dietitian/Nutrition Professional	Carrier	TBD	N/A	N/A
Rehabilitation Unit (of a Hospital)	FI Also carrier if billing practitioner services	CMS-855A CMS-855B for practitioner services	State Agency for CMS-855A	State Agency for CMS-855A
Rural Health Clinic	Regional Rural Health Clinic Intermediary Also carrier if operating as a group practice	CMS-855A CMS-855B for practitioner services	State Agency for CMS-855A	State Agency for CMS-855A
Voluntary Health/ Charitable Agency	Carrier	TBD	N/A	N/A

Figure 2-1. Medicare Enrollment Process



When Part B providers (physicians or suppliers) enroll in Medicare, the enrollment process generally proceeds as shown in Figure 2-1.

If a physician or supplier already submitted an application, and has a problem with the carrier, they should contact the CMS RO. The RO is responsible for monitoring the carrier's performance and assisting the applicant. For additional information regarding the RO, refer to Part I, Where is CMS Located?

Enrolling or Updating Enrollment Status
Each provider/supplier setting has very specific instructions for enrollment and for changing enrollment status. Detailed information can be accessed at http://www.cms.hhs.gov/MedicareProviderSupEnroll on the Web.

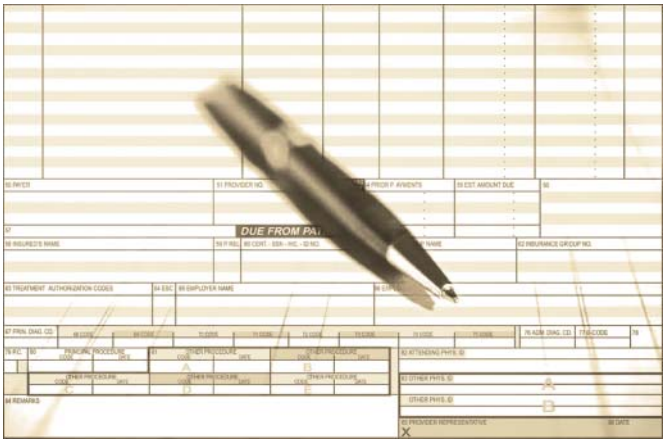
MEDICARE PROVIDER ENROLLMENT FORMS

As mentioned previously, Medicare requires physicians and suppliers to submit specific forms to enroll or update enrollment status. Previously, all Part A and Part B providers completed a lengthy and complex Form CMS-855. Since the type of information required for enrollment/updates varies by the type of provider, CMS created the following five different versions of Form CMS-855 for enrollment that are easier for providers to complete:

- **Form CMS-855A** - Healthcare providers who will bill Medicare FIs;
- **Form CMS-855B** - Healthcare providers who will bill Medicare carriers;
- **Form CMS-855I** - Individual Healthcare Practitioners (e.g., physicians and non-physician clinicians billing Medicare directly);
- **Form CMS-855R** - Individual Reassignment of Benefits (e.g. physicians and non-physician practitioners that assign their payments to a group practice); and
- **Form CMS-855S** - DME suppliers.

These Form CMS-855s are available in both electronic format (which is interactive) and Portable Data Format (PDF) to download. The electronic version is compatible with Windows 95 or above. The electronic format will allow providers and suppliers to complete the forms and save information for future use (e.g., if they must report changes). It will provide real-time edit checks and instructions for completing the form. These forms cannot be submitted electronically, but must be printed and submitted in hardcopy format. The **form must be signed and dated**, and mailed to the contractor for the provider's locality (see Figure 2-2).

Figure 2-2. CMS Forms **MUST** be Signed and Dated.



Determining Local Contractors
An applicant can determine the current contractor for a particular locality at http://www.cms.hhs.gov/MedicareProviderSupEnroll/PSEC/list.asp.

The following additional forms are often required in addition to Form CMS-855s to help facilitate physician and supplier payments:

- **Form CMS 588** - Medicare authorization agreement for electronic funds transfers;
- **Form CMS 460** - Medicare Participating Physician or Supplier Agreement; and
- **Electronic Data Interchange (EDI) Agreement**.

CMS Forms and Instructions for Completion
All of the various CMS forms and user guidance for completing these forms are available at http://www.cms.hhs.gov/MedicareProviderSup/Enroll/03_EnrollmentApplications.asp

If a physician or supplier has any questions regarding the proper completion of any of these forms, he or she should contact his or her appropriate Medicare payment contractor (carrier or DMERC) for assistance.

COMMON PROVIDER ENROLLMENT FORMS

Listed below are common questions asked by physicians or suppliers when enrolling in the Medicare Program.

Who is the authorized representative?

The authorized representative must be an officer, chief executive officer (CEO), or general partner of the organization. This individual is a person to whom the enrolling organization has granted the legal authority to:

- Enroll the organization in the Medicare Program;
- Make changes and/or updates to the organization's status in the Medicare Program (e.g., adding new practice locations, changing the organization's address, etc.); and
- Commit the organization to the laws and regulations of Medicare.

What is the effective date of enrollment in Medicare?

This date varies by provider type. The enrollee should contact his or her local carrier or the NSC for more information.

How long does the enrollment process typically take?

For most applicants, the application process will take 60 days. CMS requires its contractors to process 90% of applications within 60 calendar days of receipt or earlier, and process 99% of applications within 120 calendar days of receipt. If the applicant has not submitted all the necessary accompanying documentation, or the contractor has to request additional information, the contractor will contact the applicant initially by telephone to expedite the collection of any missing or additional information.

For certain types of providers (e.g., those that require state surveys or accreditation), it will take longer to become enrolled.

How does a provider make changes to the information on file with Form CMS-855?

Changes should be reported within 90 days of the change using the appropriate Form CMS-855, based on the physician or supplier type. Providers must complete only the first section of the form and any sections that reflect the changes, additions, or deletions being made, and then sign the certification statement.

If physicians or suppliers need to report changes to enrollment information and have not previously completed a Form CMS-855, they can still use the forms to make changes to the information. However, physicians and suppliers must furnish enough information on Form CMS-855 for the carrier or NSC to make the changes.

Is a photocopy of Form CMS-855 acceptable?

A photocopy of Form CMS-855 is acceptable. However, the signature must be original. Stamped, faxed, or copied signatures are **NOT** acceptable. Although the form may be photocopied **AFTER** it has been signed, it is unlawful to alter it in any manner once it has been signed.

Who needs a surety bond prior to participating in the Medicare Program?

Currently, neither providers nor suppliers are required to obtain surety bonds to participate in the Medicare Program.

What officials in a non-profit organization must be reported on Form CMS-855?

Managing/Directing Employees
Most non-profit organizations are run by a governing board (e.g., Board of Directors). As such, each member of the applicable governing board should be reported in the Managing/Directing Employees section of Form CMS-855.

Owners
Although the vast majority of non-profit organizations do not have owners, any individual

who owns at least 5% of the non-profit organization must be reported in the Owner Information section of Form CMS-855. If a non-profit organization has a unique organizational structure, the organization must contact their carrier or NSC for more information.

Who does Medicare recognize as a physician?

The Medicare Program defines a physician as a doctor of medicine or osteopathy (M.D. or D.O); a doctor of dental surgery or dental medicine; a chiropractor; a doctor of podiatry or surgical chiropody; or a doctor of optometry, legally authorized to practice by a state in which he or 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.

The issuance by a state for a license to practice medicine constitutes legal authorization. Temporary state licenses also constitute legal authorization to practice medicine. If state law authorizes local political subdivisions to establish higher standards for medical practitioners than those set by the state licensing board, the local

standards are used in determining whether a particular physician has legal authorization. If the state licensing law limits the scope of practice of a particular type of medical practitioner, only the services within these limitations are covered.

Does Medicare recognize medical residents and interns for payment purposes?

For Medicare purposes, the terms "interns" and "residents" include physicians participating in approved post-graduate training programs and those who are not in approved programs, but who are authorized to practice only in a hospital setting. These include, for example, individuals with temporary or restricted licenses and graduates of foreign medical schools who do not have a valid medical license. The status of a senior resident who has a staff or faculty appointment or is designated (e.g., a fellow) does not change for the purposes of Medicare coverage and reimbursement.

Generally, the FI pays services of interns and residents as physician services. Except for services furnished by interns and residents outside the scope of his or her training program, the following types of services performed by interns and residents are reimbursable to the hospital under Part B, on a reasonable cost basis:

- Services by interns and residents not in approved training programs; and
- Services performed for hospital outpatients.

Intern and Resident Services Information

The *Medicare Resident & New Physician Training Guide* provides additional details regarding intern and resident services furnished either under an approved training program, or outside an approved training program. The publication may be accessed and downloaded at http://www.cms.hhs.gov/MLNProducts on the CMS Website.

How does Medicare recognize non-physician practitioners for payment purposes?

Medicare allows payment for services furnished by non-physician practitioners. These include but are not limited to:

- Advanced registered nurse practitioners (ARNPs);
- Clinical nurse specialists (CNSs);
- Licensed clinical social workers (LCSWs); and
- Physician assistants (PAs).

To submit claims to Medicare for reimbursement, a non-physician practitioner must first apply to the program by completing Form CMS-855I and submitting the required documentation. If the application is approved, payment is allowed for the practitioner's services in all areas and settings permitted under applicable state licensure laws.

Payment to Non-Physician Practioners

No separate payment may be made to the non-physician practitioner if a facility or other physician payment is also made for such professional service.

When an ARNP or PA renders services that are integral, but incidental to a physician's service (i.e., "incident to" services), the physician's provider number should be submitted on the claim. In this situation, a provider number for the ARNP or PA is not needed. For more information, refer to the "Incident to" Policies of the carrier.

How is supplier enrollment and claims processing different than other Part B providers?

Instead of enrolling with a local carrier, DME suppliers should submit a Form CMS-855S to the National Supplier Clearinghouse (NSC) at:

P.O. Box 100142
Columbia, SC 29202-3142

Claims for supplies, orthotics, prosthetics, equipment and certain injectables are submitted to the DMERC. The beneficiary's home state determines which DMERC is responsible for processing his or her claim. To determine the appropriate DMERC, providers should contact their local carrier.

List of Available Carriers
A list of carriers is available at http://www.cms.hhs.gov/apps/contacts/incardir.asp on the web.

What does "physician/supplier specialty" mean?

Medicare Part B enrolls physicians/suppliers based on their credentials or specialties. Medicare recognizes many specialties (see Reference A for a list of provider specialties and their related codes). Physicians may have a primary specialty and a sub-specialty. Since a physician's specialty may be used to determine peer utilization review comparisons, physicians should notify the carrier of their practice's *predominant* specialty for annotation within Medicare records. No payment differential is applied to a service based on a physician's specialty. However, some non-physician/supplier specialties (e.g., PA) have a payment differential.

What is the difference between a PIN and a UPIN?

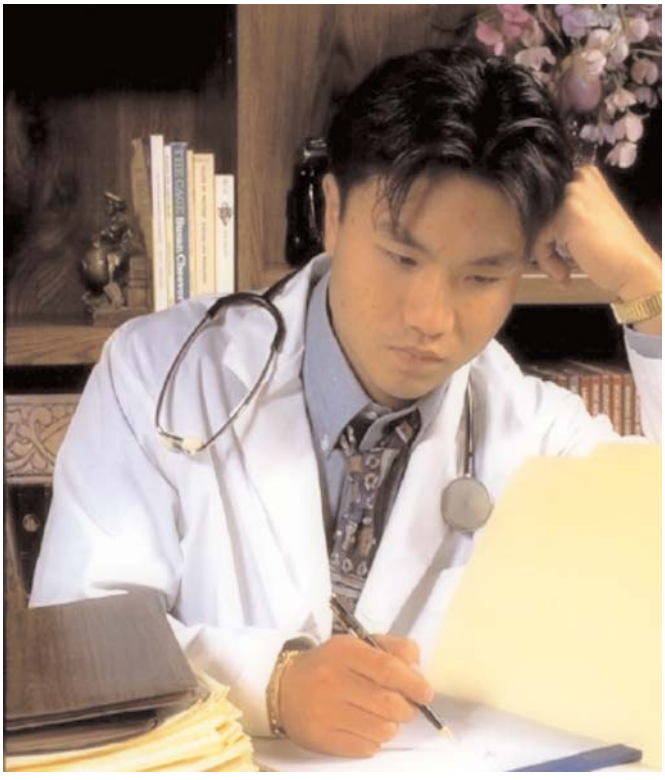
Physicians receive and must use the following identifying numbers:

- **Provider Identification Number (PIN)** - used as a provider billing number to receive reimbursement.
- **Unique Physician/Practitioner Identification Number (UPIN)** - used only when a service requires a referring or ordering physician. This number is never used as a provider billing number.

Part B providers are assigned a PIN by their carrier. The PIN identifies the facility or individual that provided the beneficiary's service and allows the provider or patient to receive reimbursement for claims filed to the Medicare payment contractor. The PIN format is unique and varies between FIs and carriers. All Medicare claims filed to payment contractors require a PIN; if a provider fails to show a PIN in the appropriate paper claim block or electronic claim field, the claim will be denied as "unprocessable".

The UPIN is assigned by CMS. It is a six-character alphanumeric code used to identify the Medicare provider. This number is assigned to physicians, non-physician practitioners, groups/clinics, and suppliers (excluding those billing to the DMERC) to identify the referring or ordering physician on a Medicare claim.

Each individual practitioner (physicians and non-physician practitioners only) receives one UPIN, regardless of the number of practice settings. The individual practitioner keeps the UPIN throughout his or her Medicare affiliation, regardless of the state in which he or she practices. CMS uses the UPIN to identify the ordering and referring physician, to aggregate



UPIN Requirements

A UPIN is required if the service is requested by:

- A referring physician who requests an item or service for a beneficiary, for which payment may be made under the Medicare Program; or
- An ordering physician who orders non-physician services for a beneficiary, such as diagnostic laboratory tests, clinical laboratory tests, or DME.

The UPIN requirement is based on the type of service, not the physician's specialty. Services currently include:

- Consultation services;
- Routine foot care;
- DME and other medical supplies;
- Orthotics/prosthetic devices, including optical supplies;
- Most diagnostic services, including laboratory and radiology services; and
- Services by independently-practicing physical or occupational therapists.

Surrogate UPINs

A surrogate UPIN is used temporarily if a UPIN has been requested, but has not yet been assigned to the ordering/referring physician. A surrogate UPIN contains three alpha characters followed by three zeros. All surrogate UPINs, except those of retired physicians (RET000), may be used only until an individual UPIN is assigned. Carriers monitor all surrogate UPINs for misuse. Surrogate UPINs require the physician's name and address. Ordering/referring physicians who may require a surrogate UPIN include:

- RES000 - intern, resident, and fellow;
- VAD000 - active U.S. military physicians and those employed by the Department of Veterans Affairs;
- PHS000 - Public Health Service physicians (including the Indian Health Service);
- RET000 - retired physician (Retired physicians must use their assigned UPIN); and
- OTH000 - when the ordering/referring physician has not received a UPIN and does not meet the criteria for one of the other surrogate UPINs; used until an individual UPIN is assigned.

When services requiring a UPIN are performed and no referring physician exists, the UPIN and name of the performing physician must be reported.

payment and utilization information for individual practitioners, to ensure compliance with contractor recommendations for sanctions, and to validate duplicate services.

What is an individual healthcare practitioner?

Individual healthcare practitioners are physicians and non-physician practitioners who render medical services to Medicare beneficiaries and submit claims for the services rendered. These practitioners must complete Form CMS-855I.

Those individual healthcare practitioners who directly bill the Medicare carrier for their services will be issued their own individual PIN. The address tied to the PIN is usually the provider's billing/mailing address, which may differ from the physical address where medical services are rendered. Often, providers do not want checks coming to their physical addresses. Many carriers can maintain two addresses in the provider's address file. Medicare may verify a new provider's address by contacting the post office, by a personal visit, or by other means.

Can an individual healthcare practitioner have multiple Medicare numbers for different practice locations?

The carrier may issue more than one PIN depending upon the physician fee localities

(geographic regions) in which a provider's practices are located. The local Medicare carrier will determine whether more than one billing number will be issued. Individuals furnishing services in multiple offices should contact their local carrier to determine if more than one number will be issued.

What is a physician-directed group/clinic practice?

A physician-directed group/clinic may be a partnership, association, or corporation composed of physicians or non-physician practitioners who wish to bill Medicare as a unit. The group must complete Form CMS-855B.

If a physician wishes to file claims as part of a group/clinic, the group/clinic must request a group/clinic PIN number for billing purposes. Each local carrier issues its own group/clinic PINs, so number formats will vary by carrier. The group/clinic PIN makes the group unique when filing services to the local carrier.

The address tied to the PIN is usually the group/clinic's billing or mailing address, which may differ from its physical address. Often, group/clinics do not want checks coming to their physical addresses. Many carriers can maintain two addresses in the provider's address file. Medicare may verify a new group's address by contacting the post office, by a personal visit, or by other means.

How do individual healthcare practitioners join or leave a group?

If both the individual healthcare practitioner and the group are already enrolled with the carrier, the individual **AND** the group together are required to complete Form CMS-855R showing the date the individual joined the group and reassigned benefits to the group. If an individual leaves a group, the individual **OR** the group should complete Form CMS-855R, showing the date the individual left the group. There is no need for Form CMS-855R to be signed by both the individual and the group; one form will suffice.

If either the individual or the group has not enrolled with the carrier, he or she or the group must first complete the appropriate Form CMS-855 for either an individual (Form CMS-855I) or group (Form CMS-855B) number before the reassignment can be effective.

What does "reassignment of benefit" mean?

Each member within the group/clinic must complete an Individual Reassignment of Benefits Form (Form CMS-855R) stating that they agree to turn all monies over to the group/clinic. After the reassignment agreement has been signed, the local Medicare carrier will tie the individual physician's PIN to the group/clinic PIN. When the group/clinic bills Medicare, they must use this provider number when filing for services performed as part of the group.

What is a "participating provider" and how does a Part B provider become one?

The term "participating provider" has the different meanings for each of the different provider types.

For physicians and suppliers, such as suppliers of DME, prosthetics, orthotics, or supplies, the term means that the Part B provider will always accept assignment on claims submitted on behalf of a Medicare beneficiary. When such a Part B provider accepts assignment, the Part B provider agrees to bill the beneficiary only for any coinsurance or deductible that may be applicable, and accepts the Medicare payment as full payment.

Part B providers generally have the option of "participating" in this regard. If a provider chooses not to participate, the provider may still bill Medicare if enrolled in the Medicare Program, but may decide on a claim-by-claim basis whether to accept assignment. However, some Part B provider specialties must always accept assignment if enrolled.

Providers who provide services under the Medicare program are required to accept assignment for all Medicare claims for the services provided. This means that the provider

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% coinsurance.

Assignment is mandated for the following claims:

- Clinical diagnostic laboratory services and physician laboratory 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, or medical nutritional therapists;
- Ambulatory surgical center services;
- Home dialysis supplies and equipment paid under Method II;
- Drugs; and
- Ambulance services.

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.

HOW CAN A PART B PROVIDER SEEK MEDICARE REIMBURSEMENT

The Medicare Program is composed of complex reimbursement systems. These systems are designed to provide necessary healthcare services to eligible beneficiaries in a manner that furnishes provider payments that reflect the actual costs of furnishing such care.

When Medicare was implemented in 1966, Medicare was a fee-for-service insurance plan. Part B providers were paid on a reasonable charge basis for most services furnished in a private office or in a Part A provider facility [e.g., Skilled Nursing Facility (SNF)]. As a result of the inflation of Medicare costs in the 1980s and 1990s, Congress mandated several changes to the Medicare reimbursement models that vary depending upon the various provider settings and services furnished.

Today, physicians and suppliers may be reimbursed through private contracts with Medicare managed care plans or through the Original Medicare fee-for-service plans. However, unlike in 1966, most Part B payment methodologies today are based upon Federally-established predetermined payments per procedure or item, rather than on cost or charges. In addition, some supplies and services can no longer be billed to a carrier if a beneficiary

Deciding Whether to Participate

Physicians, practitioners, and suppliers have only one opportunity each year to change participation status for the following calendar year (CY). This is during the carrier open enrollment period, usually in November. Each active Medicare provider receives a participation package during the open enrollment period. This package normally contains information about:

- Advantages of participating;
- Medicare Physician Fee Schedule (MPFS) allowances for the next CY;
- Proposed legislative changes that could impact the participation decision;
- Provider's current participation status and year of practice for new providers (if applicable); and
- Participating Physician or Supplier Agreement Form (which need not be completed or returned to Medicare if there is no change in participation status for the following year).

Changing Participation Status

The participation period is one year (from January 1st to December 31st). Once a provider signs a participation agreement, Medicare rarely honors a decision to change participation status during the year. However, a provider wishing to change participation status during the year must notify the local carrier's provider enrollment department and state the reason for the change. The carrier will then consider the request. A participating provider who wishes to continue participating need not sign another participation agreement. The current agreement will remain in effect until the provider notifies the carrier otherwise.

Benefits of Participation

Benefits of becoming a participating provider include the following:

- Eligibility Access: A participating provider submitting electronic media claims (EMCs) may access beneficiary eligibility files via vendor access (see Part 3, How EMC Submission Works, for more information);
- Financial: Medicare Fee Schedule allowances are about 5% higher for participating physicians. In addition, physicians who participate are not subject to limits on actual charges;
- Medigap: Claims with Medigap information will automatically crossover to the beneficiary's supplemental insurer; and
- The Medicare Participating Physicians and Suppliers Directory (MEDPARD): The MEDPARD contains a listing of all participating providers. Carriers maintain a toll-free telephone line that allows Medicare beneficiaries to request information about local participating providers. Some carriers also maintain MEDPARD on their website. Beneficiaries may also access MEDPARD at http://www.medicare.gov on the Web where more detailed physician and supplier information is available, including maps and directions to participating providers.

  Note: The directory located at http://www.medicare.gov on the Web provides an opportunity for physicians to submit updated information through an online feedback tool.

The local carrier can furnish providers with information about the participation program.

The Non-Participating Provider:

- Is held to a limiting charge when submitting nonassigned claims;
- Must file all Medicare claims for potentially reimbursable services on behalf of his or her Medicare patients;
- May collect up to the limiting charge at the time the services are rendered; and
- Is reimbursed a Medicare Fee Schedule allowance 5% lower than that of a participating provider.

Note: Pharmaceuticals, equipment, and supplies **ARE NOT** held to a limiting charge when submitting non-assigned claims.

is concurrently receiving Part A services from a SNF or home health agency (HHA).

The following section summarizes some of the key current Medicare reimbursement systems and concepts that may impact Part B providers.

MEDICARE PART B REIMBURSEMENT

Medicare Part B claim reimbursement is generally based on an established “fee-for-service” schedule for claims submitted by Part B physicians and suppliers. After deductibles, most Part B providers are reimbursed at 80% of the lower of either the established Fee Schedule,

reasonable or customary (depending on the type of physician) charge, or their billed charge for the following services:

- Physician services;
- Ambulance transportation;
- DME; and
- Diagnostic tests.

Some services are reimbursed at 100% of the lower of either the established Fee Schedule or their billed charge. These services include:

- Clinical laboratory tests;
- Influenza or pneumococcal vaccinations; and
- Other exceptions, as defined by CMS.

MEDICARE PART B PHYSICIAN FEE SCHEDULE

With few exceptions, Part B services are paid through a fixed Fee Schedule. These charges are based on three key Resource-Based Relative Value Units (RBRVUs). The RBRVU system fixes a national value for each procedure code, based on the sum of the RBRVUs associated with:

- The clinician's time, intensity, and technical skill required to render a service;
- The practice's overhead expenses, such as rent, office staff salaries, and office supplies; and
- Malpractice insurance premiums.

RBRVUs are established locally to allow for variations in practice costs among geographic areas, and each pricing locality for a given state has a Geographic Practice Cost Index (GPCI) for each RBRVU.

Physician Fee Schedules for all Medicare Part B providers are calculated using one national Conversion Factor (CF). Congress determines the CF each year, considering the projected inflation rate, projected versus actual claims volumes, Medicare enrollment changes, and other factors potentially impacting the Medicare Part B budget. Carriers and DMERCs may only establish local pricing for procedures that do not have an established national rate. The Fee Schedule is updated annually on January 1. Part B providers are furnished their local Fee Schedule by their applicable carrier or DMERC.

NON-FACILITY VERSUS FACILITY FEE SCHEDULE ADJUSTMENTS

Certain Part B services primarily performed in individual Part B provider's office settings are subject to a payment limit if performed in:

- An inpatient or outpatient hospital setting;
- A hospital emergency room;
- An SNF;
- A comprehensive inpatient or outpatient rehabilitation facility;
- An inpatient psychiatric facility; or
- An Ambulatory Surgical Center (ASC).

Medicare pays less because the physician's overhead and other related expenses are lower than they would have been in a standard office setting. Physicians are not allowed to bill the beneficiary for the difference between the actual charges and the reduced allowed amount based on the location of the service provided. If physician services are not provided in a standard office setting, the allowed amount will be the lower value of either the actual charge or the reduced Fee Schedule amount. Carriers are required to publish facility fee pricing schedules. This adjustment does not apply to outpatient rehabilitation services (physical therapy, occupational therapy, or speech-language pathology services) furnished in the mentioned facilities. Further payments would remain at the higher non-facility rate.

MEDICARE PART A REIMBURSEMENT

Although physicians and suppliers are not reimbursed by the Part A benefit, several Part A payment policies can influence payments to some physician and suppliers. Today, most Part A providers such as hospitals, SNFs, and HHAs receive payments through a Prospective Payment System (PPS) designed to cover the costs of all items and services furnished to

CMS Fee Schedule Lookup Resource

Billers who may be processing claims or claim denials can access the MPFS lookup resource at http://www.cms.hhs.gov/physicians/mpfsapp/step0.asp on the Web.

This website is designed to provide information on services covered by the MPFS. It provides more than 10,000 physician services, the associated relative value units, a Fee Schedule status indicator, and various payment policy indicators needed for payment adjustment (i.e., payment of assistant at surgery, team surgery, bilateral surgery, etc.).

The MPFS pricing amounts are adjusted to reflect the variation in practice costs from area to area. A GPCI has been established for every Medicare payment locality for each of the three components of a procedure's relative value unit (i.e., the RVUs for work, practice expense, and malpractice). The GPCIs are applied in the calculation of a Fee Schedule payment amount by multiplying the RVU for each component times the GPCI for that component.

The site allows providers to:

- Search pricing amounts, various payment policy indicators, RVUs, and GPCIs by a single procedure code, a range, and a list of procedure codes for the previous four years.
- Search for the nation, a specific carrier, or a specific carrier locality. Each page has associated Help/Hint available to complete the selections.

beneficiaries while they are under the care of that facility.

In other words, many items and services that previously were billable to carriers are now covered under "Consolidated Billing" provisions of the Part A PPS system. This means that many items (e.g., DME) and services (e.g., physical therapy services) must be billed to the FI by the facility, even if they were furnished by a Part B provider under arrangement.

Physicians and suppliers who attempt to bill carriers for such items and services will have their claims rejected. Part B providers should contact their local carrier to learn what "Consolidated Billing" provisions may apply to their provider type or services they furnish. Physicians and suppliers that furnish Medicare covered services to beneficiaries for which the "Consolidated Billing" provisions apply need to make arrangements with the hospital, SNF, or HHA receiving Part A payments to seek reimbursement.

MEDICARE MANAGED CARE REIMBURSEMENT

A *capitation rate* is a fixed amount that CMS pays to a managed care plan selected by an enrolled Medicare beneficiary. CMS pays the plan, which then reimburses the provider for services provided within the terms of the agreement/plan, regardless of the cost or amount of care provided to each Medicare beneficiary enrolled in the managed care plan.

Enrollment as a Part B provider does not ensure payment from a Medicare managed care plan. Provider reimbursement in a Medicare managed care plan is based solely upon the terms of the provider's agreement with the plan, regardless how Medicare pays for Part B services.

NOTES

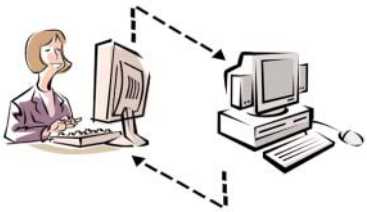
After a provider has made the decision to participate in the Medicare Program and has completed the enrollment process, the next decisions involve determining how to submit claims for payment. This chapter introduces billers to the general rules for providers regarding the claims submission process. There are several decisions providers must make depending upon the type of setting of the service, the size of the provider office, and individual business decisions. These decisions include issues such as whether to submit electronically or on paper, what claim forms and additional documentation to submit, and whether to accept assignment. In addition, consideration must be made regarding whether Medicare should be billed as the primary or as a secondary insurer, as well as what documentation is necessary to address discontinuation of care.

HOW DOES A PROVIDER SUBMIT A PART B CLAIM?

Submission of a claim, whether submitted electronically or on paper, is the only way a provider or beneficiary can receive reimbursement from Medicare. If there are discrepancies in a claim form, then the beneficiary may not receive full benefits.

Medicare Part B provider claims are submitted by providers to the carrier or the Durable Medical Equipment Regional Carrier (DMERC) using Form CMS-1500 (see Reference B for a copy of the Form CMS-1500 template and instructions for completion).

Claims can be submitted in one of two ways:



- Using Electronic Media Claims (EMCs) submitted from the provider's office or from a billing service contracting with the provider;
- Via a paper claim.

***After October 16, 2003*, providers who are not a small provider (institutional organizations with 25 or fewer full-time employees or physicians with 10 or fewer full-time employees) must submit all claims via Electronic Data Interchange (EDI) in the Health Insurance Portability and Accountability Act (HIPAA) format.**

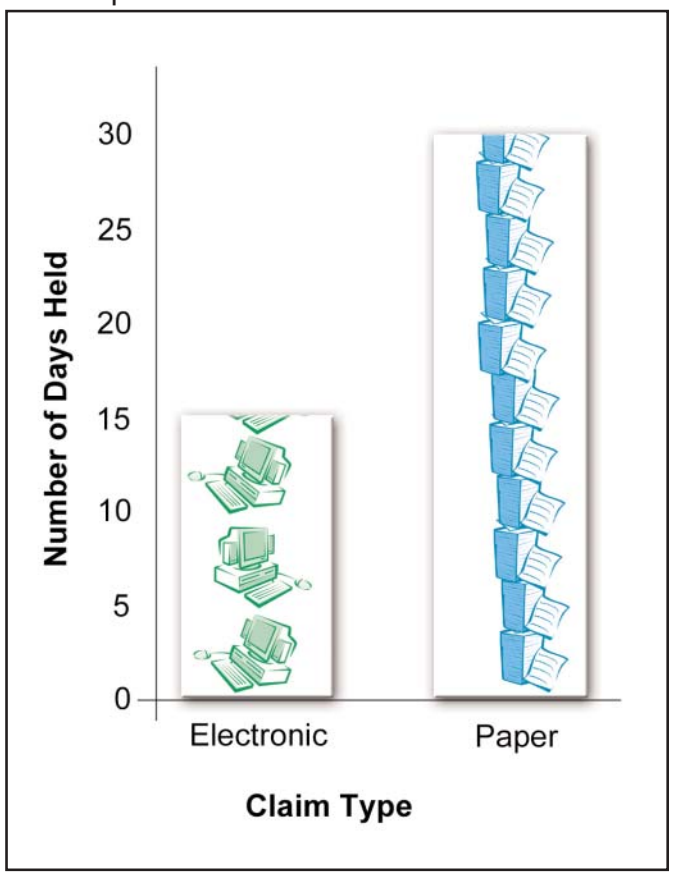
SUBMITTING CLAIMS ELECTRONICALLY

Medicare issues a sender number to a provider who intends to electronically submit Medicare claims. These EMCs are transmitted from the Part B provider's computer to the carrier or DMERC in accordance with HIPAA's American National Standards Institute (ANSI) or National Council for Prescription Drug Programs (NCPDP) electronic filing standards.

For additional information regarding HIPAA transaction standards, refer to Part 6, Introduction to HIPAA.

The EMC submission process eliminates the need for mailroom processing, thereby improving timeliness of claims. The system also releases claims payments when the Centers for Medicare & Medicaid Services (CMS) timeframe requirements are satisfied, resulting in a faster cash flow turnaround for providers. Generally, correctly filed electronic claims can be paid 14 days after the payment contractor receives the transmission, as opposed to paper claims that process in about four weeks. Payment for paper claims must be held for 28 days (see Figure 3-1).

Figure 3-1. Payment Schedule for Electronic and Paper Claims.



When a provider submits electronically, he or she will receive immediate notification that the payment contractor has received the Medicare claim. Payment contractors usually have systems that provide notification of critical claim filing errors, allowing providers to correct a claim before it enters the Medicare processing system. This process eliminates having to wait for a denial if the claim was submitted incorrectly. Providers are then able to correct rejected claims immediately and retransmit them without waiting a day.

HOW EMC SUBMISSION WORKS

The claim is electronically transmitted via modem from the Part B provider's computer to the payment contractor's computer using the Internet. The carrier's or DMERC's modem converts the claims data to the correct format and transmits it to another system, where it is electronically checked ("edited") for required information. Claims that pass these initial edits, commonly known as *front-end edits* or *pre-edits*, are then processed according to Medicare policy and guidelines. Claims with inadequate or incorrect information do **not** pass the initial edits. Instead, they are rejected and **are not paid** because they lack sufficient information to make a payment decision. Refer to Part 5, Troubleshooting Denials and Claim Rejections, for information that will help troubleshoot an unsuccessful transmission.

Additional Claims Information
Occasionally, claims require additional information before they can be completed. A development letter requesting the missing information is sent to the provider and/or beneficiary. When the information is received, the claim is processed for payment consideration. Failure to respond to a request for additional development may result in denial of a provider's claim.

After a successful transmission, a confirmation report or acknowledgement report is generated and is either transmitted back to the provider or placed in an electronic mailbox for the provider to download. The provider should immediately review this report carefully. The report indicates the numbers of claims accepted and the total dollar amount transmitted.

Certificate of Medical Necessity (CMN)
Providers who submit claims electronically gain access to additional functions such as CMNs. For certain items or services billed to the DMERC, the supplier must receive a signed Certificate of Medical Necessity (CMN) from the treating physician. When CMNs are submitted electronically to the DMERC, only information in Sections A, B, and D of the CMN are required since the information in Section C cannot be transmitted electronically. However, suppliers who bill electronically are not exempt from completing Section C of the original CMN. Please refer to Chapter 5, Section 3.3, of the *Medicare Program Integrity Manual,* which is available at http://www.cms.hhs.gov/manuals/108_pim/pim83c05.pdf on the Web. The local DMERC should also be able to provide additional information regarding completion of CMNs.

CMNs may be used when submitting claims for ambulances, cataract glasses, chiropractor, Durable Medical Equipment (DME), oxygen, and certain types of podiatry services.

Note: CMNs are not necessary for every claim and, if necessary, are not always required with the initial claim submission. The local carrier can provide additional information.

However, this report will also list the claims that were rejected, as well as the reason(s) for being rejected. At this point, the provider can make the necessary corrections to the claim(s) and resubmit them immediately.

The following are alternatives for electronically submitting claims data:

- Providers may work through a software vendor who can provide the level of practice management system support needed for the provider's practice setting;
- Providers may submit their Medicare claims directly to the payment contractor or choose to submit claims through a clearinghouse;
- Providers may choose to have a billing agent handle all or part of the Medicare billing; or
- If the provider's office has the required hardware, they may choose to use Medicare's free billing software.

Additional EMC Benefits
In addition to the day-to-day benefits of EMC, other features are available to electronic filers:

- Eligibility Access: Participating providers who file claims electronically may acquire access to beneficiary eligibility files through their vendor. The provider can determine if a patient is eligible for Medicare benefits, has met the Medicare deductible, is enrolled in a Health Maintenance Organization (HMO), or is entitled to Medicare where Medicare is the secondary payer.
- Electronic Remittance Notification (ERN): An EMC provider can receive paid and/or denied claims information electronically from the Medicare Part B system. ERN may be used to automatically update provider accounts receivable files or the patient billing system. ERN is the equivalent of the Medicare Remittance Notice (MRN) form and can eliminate the need to manually post payments.
- Electronic Claims Status (ECS): EMC providers may obtain a paper or electronic list of all Medicare pending claims 14 days or older for tracking and monitoring.
- Electronic Funds Transfer (EFT): With EFT, Medicare Part B can send payments directly to a provider's financial institution whether claims are filed through EMC or on paper.

HOW TO APPLY FOR EMC SUBMISSION

To submit an Electronic Media Claims (EMC) claim using EDI in HIPAA format, the CMS Standard EDI Enrollment Form must be completed prior to submitting the EMC to Medicare. This form must be submitted by each physician, supplier, or group that intends to submit an EMC. Each new EMC biller must sign the form and submit it to his or her local Medicare carrier or DMERC. In addition, any existing EMC billers who have not completed the CMS Standard EDI Enrollment Form must also complete and sign this form and submit it to their local carrier or DMERC.

An organization comprised of multiple components that have been assigned Medicare provider numbers, supplier numbers, or Unique Physician Identification Numbers (UPINs) may elect to execute a single EDI Enrollment Form on behalf of the organizational components to which these numbers have been assigned. The organization as a whole is to be held responsible for the performance of its individual components.

Local Carrier and DMERC Help Lines
A list of local carrier and DMERC EDI Help Lines is available at http://www.cms.hhs.gov/ElectronicBillingEDITrans on the CMS website.

CMS EDI Standard Enrollment Form
Additional information regarding the CMS Standard EDI Enrollment Form is available at http://www.cms.hhs.gov/providers/edi/edi5.asp on the Web.

An electronic copy of the CMS Standard EDI Enrollment Form in Portable Document Format (PDF) is available at http://www.cms.hhs.gov/ElectronicBillingEDITrnas/16_1500.asp on the CMS website.

HIPAA Compliance Code Sets
If submitting electronically, the following medical code sets apply:

- ICD-9-CM (Volumes 1 & 2) - used to indicate diseases, injuries, impairments, or other health problems and their manifestations. Also used to indicate causes of injury, disease, impairment, or other health problems; or
- ICD-9-CM (Volume 3) - used to indicate prevention, diagnosis, treatment, and management of a disease; or
- National Drug Codes (NDC) - used to indicate drugs and biologics used on retail pharmacy transactions; or
- Current Dental Terminology (CDT) - used to indicate American Dental Association (ADA) services; or
- HCPCS and Current Procedural Terminology (CPT)-4 - used to indicate physician and other health care services to include physician services, physical and occupational therapy services, radiologic procedures, clinical laboratory tests, medical diagnostic services, hearing and vision services, and transportation services (including ambulance); or
- HCPCS - used to indicate equipment, supplies, or other items used in health care services to include supplies such as medical supplies, orthotic and prosthetic devices, or DME.

Important Note: The National Correct Coding Initiative (NCCI) pertains specifically to HCPCS and CPT codes and helps physicians to correctly code claims submissions by providing the most recently edited code information. All physicians should access this information at http://www.cms.hhs.gov/physicians/cciedits/ on the Web.

SUBMITTING PAPER CLAIMS

Today, only a limited number of providers are permitted to submit paper claims. **After October 16, 2003**, providers who are not a small provider (institutional organizations with 25 or less full-time employees or physicians and suppliers with 10 or less full-time employees) must submit all claims via EDI in HIPAA format. In addition, unlike EMC claims that can be paid within 14 days, paper claims cannot be paid until 28 days after the payment contractor has received a "clean" (i.e., error-free) claim. Before submitting paper claims, providers should contact their carrier to identify the most effective options for submitting such claims. In addition, when submitting a claim to Medicare for tertiary payment (i.e., there is more than one primary payer), these claims must be submitted in paper hardcopy to Medicare.

Submitting a "Black and White" Form CMS-1500

There are some carriers who will accept "black and white" copies of Form CMS-1500, and copies containing handwritten instead of typed entries. If a carrier does accept such a form, the provider may not be required to submit the back side of the form if a signed attestation statement is filed with the carrier on an annual basis. This statement should say, "…he or she has read the reverse side of Form CMS-1500 and understands the requirements and agrees to comply with applicable Medicare billing requirements." These options vary by carrier.

HOW PAPER CLAIM SUBMISSION WORKS

Some payment contractors process claims using Optical Character Recognition (OCR), an automated scanning process similar to scanners that read price labels in grocery stores. OCR claims processing is faster and more accurate than systems requiring manual input. However, to work properly, OCR must accurately read and interpret the characters entered in each field. It reads only typed or machine-printed data. If a carrier uses OCR software for automated claims processing, only an original, red and white Form CMS-1500 may be submitted.

After the claims information is scanned, it is transmitted to the claims processing system where it is validated and compared to other data until final processing occurs.

To ensure quick and accurate claim processing, the following guidelines should be followed:

- Do not staple, clip, or tape anything to the Form CMS-1500.
- Place all necessary documentation in the envelope with the Form CMS-1500.
- Put the patient's name and Medicare number on each piece of documentation submitted.
- Use dark ink.
- Use only upper-case (CAPITAL) letters.
- Use 10 or 12 pitch (pica) characters and standard dot matrix fonts.
- Do not mix character fonts on the same form.
- Do not use italics or script.
- Avoid using old or worn print bands or ribbons.
- Do not use dollar signs, decimals, or punctuation.
- Enter all information on the same horizontal plane within the designated field.
- Do not print, hand-write, or stamp any extraneous data on the form.
- Use only lift-off correction tape to make corrections.
- Ensure data is in the appropriate field and does not overlap into other fields.
- Remove pin-fed edges at side perforations.
- Use only an original red-ink-on-white-paper Form CMS-1500 (12-90) claim form.

Form CMS-1500 Claim Form Information
Providers can view information regarding paper claims filing and download copies of claim forms at http://www.cms.hhs.gov/ElectronicBilling EDI Trans on the CMS website.

Official red-printed Form CMS-1500s are available for purchase from various vendors. They are also available in various formats from the U.S. Government Printing Office (GPO). Negatives are also available from the GPO. Contact the GPO at 1-866-512-1800 or mail publication order inquiries to:

Superintendent of Documents
P.O. Box 371954
Pittsburgh, Pennsylvania 15250-7954

Providers can also contact the GPO for printing information at http://bookstore.gpo.gov on the Web.

WHAT IS A REMITTANCE ADVICE (RA)?

After Medicare processes a claim, a RA is sent to the provider. The RA can take the form of a Standard Paper Remittance (SPR) Advice Notice or an Electronic Remittance Advice (ERA).

The SPR format corresponds to the ERA format. The ERA format is the HIPAA standard format, also known as ASC X12 Transaction 835 (Healthcare Claim Payment/Advice) version 4010A1. This standard format is also referred to as the "Transaction 835". The Transaction 835 is intended to meet the particular needs of the healthcare industry for the payment of claims and the transfer of remittance information.

The Transaction 835 contains Health Care Claim Adjustment Reason Codes and RA Remark Codes. Health Care Claim Adjustment Reason Code and RA Remark Code sets have been adopted under HIPAA as the standard code sets to be used in the standard Transaction 835. These codes are key elements for providing detailed payment adjustment information relative to a healthcare claim(s). If applicable, these codes also describe why the total original charges have not been paid in full.

Health Care Claim Adjustment Reason Codes communicate an adjustment, meaning that they must communicate why a claim or service line was paid differently than it was billed. If there is no adjustment to a claim/line, then there is no Health Care Claim Adjustment Reason Code. Under HIPAA, it is important to understand the term "adjusted". Adjusted indicates that there is a denied payment, zero payment, partial payment, reduced payment, penalty applied, additional payment, or supplemental payment.

RA Remark Codes are used within the Transaction 835 to convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a Health Care Claim Adjustment Reason Code. An RA Remark Code may be used at either the claim or service line level if it is appropriate for the specific situation. Use of an RA Remark Code at the claim level conveys information about claim level adjustments or about the overall processing of the claim. Use of RA Remark Codes at the line level conveys information about adjustments for the specific service line or about the processing of those services. Since RA Remark Codes provide information about remittance processing or further explain an adjustment, RA Remark Codes will seldom be used unless there is an adjustment to report.

Lastly, it is important to understand the difference between a Health Care Claim Adjustment Reason Code and an RA Remark Code. Health Care Claim Adjustment Reason Codes explain an adjustment (an amount paid that is different than the amount billed, including a zero payment or a denial) to the amount submitted by the provider. RA Remark Codes accomplish two

purposes. They convey informational messages about general remittance practices or they provide a supplemental explanation for an adjustment already described by a Health Care Claim Adjustment Reason Code. It is important to review the Health Care Claim Adjustment Reason Codes and the RA Remark Codes, along with other information regarding the Transaction 835. The codes help the biller understand the specific business reason for any denial or reduction in payment before making an inquiry to Medicare.

RA Code Information
The most current code list and a description of Health Care Claim Adjustment Reason Codes and RA Remark Codes can be found at http://www.wpc-edi.com/codes/Codes.asp on the Web. These code lists are updated three times a year and posted during May, July, and November. See Reference F for a list of approved Health Care Claim Adjustment Reason Codes per the most recently posted update at the time of printing. See Reference G for a list of RA Remark Codes per the most recently posted update at the time of printing.

In addition to this notice, Medicare notifies the beneficiary using a Medicare Summary Notice. The format of notification that the beneficiary receives depends on the carrier or DMERC processing the claim.

***If the provider receives an RA electronically*, he or she must be ready to receive the notice in HIPAA standard format (ASC X12N Transaction 835 version 4010A1) by October 16, 2003.**

ARE THERE ANY SPECIAL CONSIDERATIONS WHEN SUBMITTING CLAIMS?

Depending on the specialty of the Part B provider, there are additional special considerations a biller will be involved in when submitting claims. These considerations include:

- Deciding whether to accept assignment;
- Determining whether Medicare should be billed first;
- Submitting Certificates of Medical Necessity (CMNs);
- Providing Advance Beneficiary Notices (ABNs);
- Providing Notices of Medicare Benefits (NEMBs); and
- Deciding whether to submit additional documentation with the initial claim.

ACCEPTING OR NOT ACCEPTING ASSIGNMENT

Certain Part B providers must always accept Medicare payments while other physicians, practitioners, and suppliers may choose to enter into a participating agreement. Carriers who are “participating providers” are paid at 100% of the physician Fee Schedule and must accept assignment. This means that they must accept Medicare payment as payment in full, except for any unmet deductible and coinsurance that would be the patient's responsibility.

However, “non-participating providers” are paid at 95% of the fee schedule (less deductible and coinsurance) and may accept assignment on a claim-by-claim basis. Beneficiary liability for coinsurance of non-participating providers varies by type of provider service, and the provider may be subject to a limiting charge.

Also, regardless of participation, some suppliers and practitioner types are required to accept assignment. See Part 2, Common Provider Enrollment Questions, for additional information

regarding assignment, participation, and non-participation.

All physicians and suppliers are required to file claims with carriers and DMERCs on behalf of all beneficiaries within one year from the date of service per the Omnibus Budget Reconciliation Act (OBRA) of 1989. Regardless of the type of claim, providers may never charge Medicare patients for completing or filing a claim. Proper completion and submission of a "clean" (i.e., error-free) Medicare claim is the first step in accurate claims processing. Clean claims are claims that successfully process without system-generated requests for additional information.

SUBMITTING ASSIGNED CLAIMS

Either a participating or a non-participating Part B provider may file assigned claims for any Part B claim. The provider is held to the assignment agreement for that claim only and agrees to accept the Medicare fee schedule amount as payment in full for all covered services. The provider is reimbursed directly. To accept assignment of Medicare benefits for a claim, the Part B provider must check "Yes" in Item 27 on Form CMS-1500 (see Figure 3-2). Providers may collect reimbursement for excluded services, unmet deductible(s), and coinsurance amounts from the beneficiary.

Figure 3-2. Check "Yes" to Accept Assignment.

Assignment is mandatory for the following claims:

- Clinical diagnostic laboratory services and physician laboratory services;
- Physician services to individuals dually entitled to Medicare and Medicaid;
- Services of physician assistants (PAs), advanced registered nurse practitioners (ARNPs), clinical nurse specialists (CNSs), nurse midwives, certified registered nurse anesthetists, clinical psychologists, clinical social workers, and medical nutritional therapists;
- Ambulatory Surgical Center (ASC) services;
- Home dialysis supplies and equipment paid under Method II;
- Drugs; and
- Ambulance services.

For practitioner services of physicians, and services of independently practicing physical and occupational therapists, the acceptance of assignment is not mandatory. Acceptance of assignment is also not mandatory for suppliers of radiology services or diagnostic tests. However, these practitioners and suppliers may voluntarily agree to participate in taking advantage of the higher payment rate, in which case the participation status makes assignment mandatory for the term of the agreement.

SUBMITTING NON-ASSIGNED CLAIMS

Only a non-participating provider may file non-assigned claims. A non-participating provider does not agree to accept Medicare's allowed amount as payment in full and may charge the beneficiary or the service(s) up to the limiting charge. The limiting charge is the maximum amount that a non-participating provider may charge the beneficiary.

The limiting charge applies to all of the following services/supplies, regardless of who provides or bills for them:

- Physicians' services;
- Services and supplies furnished incidental to physician's services that are commonly furnished in a physician's office;
- Outpatient physical and occupational therapy (OT) services furnished by an independently practicing therapist;

- Diagnostic tests; and
- Radiation therapy service, including X-ray, radium, and radioactive isotope therapy, materials, and technician services.

The limiting charge is 115% of the Fee Schedule amount.

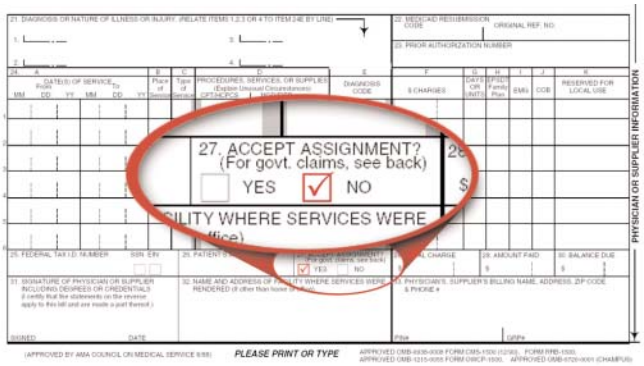
Example of a Limiting Charge

Medicare Fee Schedule allowed amount = $200.00
Non-participating provider allowed amount = $190.00 (95% of $200)
Limiting charge = $218.50 ($190 x 1.15)
Maximum beneficiary coinsurance to non-participating provider = $28.50 ($218.50 - $190.00)

Note: The limiting charge provision does not apply to certain equipment and supplies. Please contact the carrier for details. Limiting charge provisions also do not apply when Medicare is secondary to another insurance. A non-participating provider may round the limiting charge to the nearest dollar if done consistently for all services.

When a non-participating provider files a Part B non-assigned claim, the beneficiary is reimbursed directly. To refuse assignment of Medicare benefits for a claim, the provider must check "No" in Item 27 of Form CMS-1500 (see Figure 3-3).

Figure 3-3. Check "No" to Refuse Assignment.



SUBMITTING MEDICARE SECONDARY PAYER (MSP) CLAIMS

Medicare Secondary Payer (MSP) is the term used when Medicare is not responsible for making the primary payment on beneficiary health care claims. All healthcare providers and suppliers are required to determine, prior to billing, whether Medicare is the primary or secondary payer. Medicare becomes the secondary payer when other primary insurance exists.

MSP REGULATIONS

Until 1980, the Medicare program was the primary payer in all situations except those involving Workers' Compensation (WC) (including Federal Black Lung) benefits. Since 1980, changes in the Medicare law have resulted in Medicare being the secondary payer in other situations. The MSP program protects Medicare funds and ensures that Medicare does not pay for services reimbursable under private insurance plans or other government programs. Medicare may not pay if payment has been made, or can be reasonably expected to be made, with respect to an item or service that is covered under other health insurance or coverage.

MEDICARE COORDINATION OF BENEFITS (COB) CONTRACT

In November 1999, CMS embarked on an important initiative to expand its campaign against Medicare waste, fraud and abuse under the Medicare Integrity Program by awarding the COB contract. The COB initiative to consolidate activities that support the collection, management, and reporting of other insurance coverage of Medicare beneficiaries became effective as of April 2000.

The purpose of the COB program is to identify health benefits available to a Medicare beneficiary and to coordinate the payment process to prevent and minimize overpayments of Medicare benefits. Information on eligibility

and benefits entitlement is obtained from the COB central file and is used to facilitate accurate payment.

The COB program provides many benefits for employers, providers, physicians, suppliers, third-party payers, attorneys, beneficiaries, and Federal and State programs. All MSP claim investigations are initiated and researched by the COB contractor, not by the local Medicare FI or carrier. This one-step approach minimizes the number of duplicate MSP investigations. It offers a centralized, one-stop customer service approach for all MSP-related inquiries, including those on general MSP information (but not related to specific claims or recoveries that serve to protect the Medicare Trust Fund). The COB contractor provides customer service to all callers from any source, including but not limited to beneficiaries, attorneys, or other beneficiary representatives, employers, insurers, providers, physicians, suppliers, and other health plans.

A variety of methods and programs is used by the COB contractor to identify situations in which Medicare beneficiaries have other health insurance that is primary to Medicare. FIs and carriers will continue to process claims submitted for primary or secondary payment. Claim processing is not a function of the COB contractor.

MSP Inquiries
Refer all MSP inquiries to the COB contractor at 1-800-999-1118 or TDD/TYY 1-800-318-8782.
Contact the local FI and/or carrier regarding claims and/or recovery-related questions.

Note: All possible insurers must be identified. There may be situations in which more than one insurer is primary to Medicare (e.g., liability or no-fault insurer, GHP).

BENEFITS OF THE MSP PROGRAM

The successful implementation of the MSP Program has resulted in positive benefits for Medicare, providers, suppliers, and the patient. Benefits include the following:

- National program savings - Claims are paid by insurers that are primary to Medicare, resulting in a national program savings in excess of $4 billion dollars annually.
- Increased revenue - A provider or supplier that bills a liability insurer is entitled to pursue full charges. Receiving more favorable reimbursement is to the advantage of the provider or supplier. In many instances, insurance companies that are primary will pay the entire amount billed, rather than only the amount authorized under Medicare.
- Lower out-of-pocket expenses - Multiple insurance coverages often reduce the amount a patient is obligated to pay, which includes satisfying deductible amounts and preserving Medicare coverage limits.

WHEN MEDICARE IS CONSIDERED SECONDARY

The MSP law makes Medicare the secondary payer to insurance plans and programs under certain conditions. Three provisions of the MSP law require Medicare to be secondary payer related to GHPs. These provisions are working-aged, end-stage renal disease (ESRD), and disability. Other provisions of the MSP law require Medicare to be secondary payer relating to disease or accidents as a result of employment or coverage available under WC, liability, or no-fault insurance.

In addition, services authorized under the Veterans Health Administration (VHA) and other government programs such as research grants are primary to Medicare even though they are not specific MSP provisions.

When Medicare is the secondary payer, the other payer pays first and Medicare pays second. A brief description of situations in which MSP billing applies follows:

- **Services Payable Under GHP Benefits**

  Working-Aged - Medicare benefits are secondary to benefits payable under a GHP for individuals age 65 or over who have GHP coverage as a result of their own current employment status or the current employment status of a spouse of any age. Specific conditions when this applies:

  - MSP requires employers of 20 or more employees to offer their "working-aged" employees and their spouses age 65 and over the same GHP offered to other employees.
  - Medicare is the secondary payer to a GHP when a single employer with 20 or more employees (as determined by the IRS) sponsors or contributes to the GHP, or when multiple employers sponsor or contribute to the GHP and at least one of them has 20 or more employees.

ESRD - Medicare benefits are secondary to benefits payable under a GHP for individuals under age 65 who are eligible for, or entitled to, Medicare based on ESRD during a Medicare coordination period, as described in Table 3-1. Specific conditions when this applies:

Table 3-1. Stages of End-Stage Renal Disease Coverage (ESRD) Under a Group Health Plan (GHP).

Stage	Timeframe	What Happens:
Stage 1 Waiting Period for Eligibility	Three months from the first day of dialysis.	If GHP coverage is available, the GHP is primary and there is no Medicare coverage during the waiting period.
Stage 2 Coordination Period	Begins with eligibility/entitlement for Medicare based on ESRD. For eligibility/entitlement beginning prior to 3/1/96, Coordination Period lasts 18 months. For eligibility/entitlement periods beginning on or after 3/1/96, Coordination Period lasts 30 months.	GHP is primary and Medicare is secondary.
Stage 3 Primary Medicare Benefits	After Coordination Period, and until Stage 4 occurs.	Medicare is primary and GHP is secondary.
Stage 4 End of Medicare Benefit	When patient has ceased dialysis treatments for 12 months. OR 36 months after successful kidney transplant.	Only GHP coverage is available.

ESRD Information
Medicare entitlement can start earlier in some cases where the beneficiary received a kidney transplant, or is taking part in a home dialysis training program and expects to complete the training period within the first three months of dialysis. There is a separate coordination period each time a beneficiary becomes eligible for Medicare based on kidney failure. Entitlement can be resumed without a waiting period. For additional information, see the publication entitled *Medicare Coverage of Kidney Dialysis and Kidney Transplant Services* available at http://www.medicare.gov/Publications/Pubs/pdf/10128.pdf on the Web. If a GHP does not pay the entire charge for items or services furnished to a beneficiary, Medicare will make secondary payments, taking into account:

- The amount the GHP has allowed; and
- The amount Medicare considers reasonable for those items or services.

If the GHP provides no benefits at all for particular medically necessary services (e.g., a kidney transplant), Medicare may pay for those services as primary payer, assuming the services are covered under Medicare.

- Persons with ESRD who can receive secondary Medicare are beneficiaries also covered by a GHP or beneficiaries who are the family members of someone covered by a GHP.

Disabled Beneficiaries Covered Under a Large Group Health Plan (LGHP) - Medicare benefits are secondary to benefits provided by GHPs for certain disabled individuals under age 65 who have coverage based on their own current employment status or the current employment status of a family member.

Specific conditions when this applies:

- Persons who can receive secondary Medicare due to disability are disabled beneficiaries covered by an LGHP (100 or more employees), or they are a family member of someone who is covered by an LGHP.

- **Services Related to Liability or No-Fault Insurance Coverage or Employment Related Disease or Accidents**

  Liability or No-Fault Insurance - Medicare benefits are secondary to payments that have been issued, or can reasonably expect to be made promptly for items or services under liability or no-fault insurance. Medicare is secondary to liability or no-fault insurance even if state law or a private contract of insurance stipulates that its benefits are secondary benefits, or otherwise limits payments to Medicare beneficiaries.

  Employment Related Disease or Accidents - Medicare is secondary payer to WC plans (including Federal Black Lung benefit programs). Payment under Medicare may not be made for any items or services if payment has been made, or can reasonably be expected to be made under a WC law or plan. If services are furnished that are not payable by WC, then Medicare is primary payer for those services.

- **Other Services Where MSP Provisions Apply**

  VHA - The VHA pays for health care services rendered (usually at VHA facilities) to persons who have served in the armed forces. When the VHA is unable to provide services at one of its facilities, they may authorize non-Federal providers and suppliers to do so at Federal expense. When VHA authorized items or services are provided at a non-Federal facility, Medicare does not make payment for such

items or services. Details about the VHA payment policy are provided within the *Medicare Benefit Policy Manual*, Chapter 16, §50.1, which is available at http://www.cms.hhs.gov/manuals/102_policy/bp102c16.pdf on the Web.

Note: Eligibility coverage may change during a course of treatment. Providers and suppliers are required to query Medicare patients to determine if any of these MSP conditions apply.

Table 3-2 lists some common situations when Medicare is the primary and secondary payer.

MSP INFORMATION THAT PROVIDERS OR SUPPLIERS SHOULD OBTAIN FROM A BENEFICIARY OR REPRESENTATIVE

Providers and suppliers are required by law to collect information from beneficiaries regarding the availability of other health insurance related to the items or services included on the claim. In addition, Medicare regulations require that providers and suppliers must agree "to bill other primary payers before billing Medicare"[1]. Thus, any provider that bills Medicare for items and services must determine whether or not Medicare is the primary payer. This must be accomplished by asking beneficiaries, or their representatives,

Table 3-2. List of Common Situations When Medicare May Pay First or Second.

If the patient...	And this condition exist...	Then this program pays first...	And this program pays second...
Is age 65 or older, and is covered by a General Health Plan (GHP) through a current employer...	The employer has less than 20 employees...	**Medicare**	GHP
	The employer has 20 or more employees or at least one employer is a multi-employer group that employs 20 or more individuals...	GHP	**Medicare**
Has an employer retirement plan and is age 65 or older, or disabled and age 65 or older...	The patient is entitled to Medicare...	**Medicare**	Retiree coverage
Is disabled and covered by a Large Group Health Plan (LGHP) from work, or from a family member who is working...	The employer has less than 100 employees...	**Medicare**	GHP
	The employer has 100 or more employees, or at least one employer is a multi-employer group that employs 100 or more individuals...	LGHP	**Medicare**
Has end-stage renal disease (ESRD) and GHP coverage...	Is in the first 30 months of eligibility or entitlement to Medicare...	GHP	**Medicare**
	After 30 months...	**Medicare**	GHP

[1] 42 CFR489.20(g)

If the patient...	And this condition exist...	Then this program pays first...	And this program pays second...
Has ESRD and COBRA coverage...	Is in the first 30 months of eliligibility or entitlement to Medicare...	COBRA	**Medicare**
	After 30 months...	**Medicare**	COBRA
Is covered under Workers' Compensation (WC) because of a job-related illness or injury...	The patient is entitiled to Medicare...	WC (for health care items or services related to job-related illness or injury)	**Medicare**
Has black lung disease and is covered under the Federal Black Lung Program...	The patient is eligible for the Federal Black Lung Program...	Federal Black Lung Program (for healthcare services related to black lung disease)	**Medicare**
Has been in an accident where no-fault or liability insurance is involved...	The patient is entitled to Medicare...	No-fault or liability insurance (for accident related health care services)	**Medicare**
Is age 65 or older OR is disabled and covered by Medicare and COBRA...	The patient is entitled to Medicare...	**Medicare**	COBRA
Has Veterans Health Administration (VHA) benefits...	Receives VHA authorized health care services at a non-VHA facility...	VHA	Medicare may pay when the services provided are Medicare covered services and are not covered by the VHA

questions concerning the beneficiary's MSP status. If providers fail to provide correct and accurate claims with Medicare, regulations permit Medicare to recover its conditional payments to them.

COLLECTING BENEFICIARY MSP INFORMATION

Generally, Medicare policy requires providers to update beneficiary MSP information for every admission, outpatient encounter, or start of care prior to submitting a bill to Medicare. However, there are some exceptions.

When COBRA Applies
COBRA is a law that requires employers with 20 or more employees to allow employees and their dependents to keep their group health coverage for a time after they leave their GHP. This is called continuation coverage and can last up to 18, 29, or 36 months in some cases. COBRA and Medicare interact as follows:

- If the beneficiary or spouse are age 65 or over and have COBRA, Medicare is the primary payer.
- If the beneficiary or family member has Medicare based on disability and has COBRA, Medicare is the primary payer.
- If the beneficiary or family member has Medicare based on ESRD, COBRA is the primary payer for a 30-month period and Medicare is secondary.

Set-Aside Arrangements for WC Settlements
Medicare may remain the secondary payer even after a WC settlement. If a WC settlement includes compensation for future treatment of medical conditions related to the work-related illness or injury, and CMS approved the amounts that were set-aside to consider Medicare's interests, then those amounts are referred to as a set-aside arrangement.

In these situations, providers and suppliers would only bill the set-aside account. Once the set-aside account is depleted, Medicare becomes primary. The beneficiary's set-aside balance can be checked by contacting the carrier or administrator of the set-aside arrangement.

Billing Requirement Exceptions
For additional information regarding those exceptions, refer to Chapter 3, MSP Provider Billing Requirements, of the *Medicare Secondary Payer (MSP) Manual*, which is available at http://www.cms.hhs.gov/manuals/105_msp/msp105c03.pdf on the Web.

SPECIFIC BENEFICIARY MSP INFORMATION THAT MUST BE COLLECTED

The questionnaire provided within Reference D contains questions that should be asked of Medicare beneficiaries upon each start of care. Providers can use this questionnaire as a guide to help identify other payers that may be primary to Medicare. Starting with Part 1 of the questionnaire, the provider should ask the patient each question in sequence. By following the instructions included on the questionnaire, the provider will be able to identify who should pay first.

ONLINE VERIFICATION OF MSP INFORMATION

Providers with online capability may now access the following MSP information via the Common Working File (CWF) MSP auxiliary file:

- MSP effective date;
- MSP termination date;
- Patient relationship;
- Subscriber name;
- Subscriber policy number;
- Insurer type;
- Insurer information to include name, group number, address, city, state, and ZIP code;
- MSP type;
- Remarks code;
- Employer information to include name, address, city, state, and ZIP code; and
- Employee data to include ID number.

At the provider's discretion, these data may be viewed during either the admission or the billing process. However, the data must be viewed before the bill is submitted to Medicare. If used during admission, the provider can verify the

accuracy of each data element using the questions found in the questionnaire provided within Reference D (see Part III, Specific Beneficiary MSP Information that Must be Collected).

RETENTION REQUIREMENTS FOR MSP DOCUMENTATION

The provider should retain a copy of the completed admission questionnaires on-file or online for audit purposes. This demonstrates that the provider has investigated with the beneficiary to determine if there is other primary payer coverage. The beneficiary does not need to sign the forms. It is prudent for providers to retain these records for 10 years in a paper, optical image, microfilm or microfiche, or online format.

SUBMITTING AN MSP CLAIM

Specific instructions for submitting MSP claims are included in Chapter 3, MSP Provider Billing Requirements, of the *Medicare Secondary Payer Manual*.

Instructions for Submitting MSP Claims
The *Medicare Secondary Payer Manual* containing instructions for submitting MSP Claims is available at http://www.cms.hhs.gov/manuals/10M/list.asp on the CMS website.

WHEN MEDICARE PAYS FIRST IN AN MSP SITUATION

Medicare will pay first in an MSP situation called "Conditional Primary Medicare Benefits". There is frequently a long delay between occurrence of an injury and the decision by the State WC agency in cases where compensability is being contested or is in a comparative liability action. A denial of Medicare benefits pending outcome of the final decision means that beneficiaries might be required to advance their own funds to pay for expenses that are eventually borne by WC, the liability insurer, the no-fault insurer, or Medicare. To avoid imposing hardship on Medicare beneficiaries pending such decision, conditional Medicare payments may be made. Such payments are conditional upon reimbursement to the Medicare Trust Fund if it is later determined that the services are covered by WC, the no-fault insurer, or the liability insurer. Conditional payments may also be paid for services denied in limited situations.

Conditional primary Medicare benefits may be paid if the beneficiary, provider, physician or supplier has filed a proper claim with the applicable primary insurer (state WC, liability, and/or no-fault plan), and:

- Payments expected from the applicable plans are not paid promptly (i.e., within 120 days of receipt of the claim at a minimum) for any reason except when the plan claims that its benefits are secondary to Medicare; or
- The properly submitted claim was denied in whole or in part; or
- Because of physical or mental incapacity of the beneficiary, a proper claim was not filed with the primary insurer.

When such conditional Medicare payments are made, they are made on the condition that both the insurer and beneficiary will reimburse the program to the extent that payment is subsequently made by the insurer.

MSP Patient and Staff Education
A plain language MSP publication for patient and staff education entitled *Medicare and Other Health Benefits: Your Guide to Who Pays First* is available at http://www.medicare.gov/Publications/Home.asp on the Web.

Additional MSP Information
Additional MSP information can be obtained from the following resources:

- The *Medicare Secondary Payer (MSP) Provider Billing Requirements Manual* available at http://www.cms.hhs.gov/manuals/10M/list.asp on the CMS Website;
- The Medicare COB contractor at 1-800-999-1118;
- The carrier who can answer questions pertaining to claims-related information;
- Frequently Asked Questions (FAQs) available at http://www.cms.hhs.gov/ on the Web. Click the FAQs option on the top toolbar to access the FAQ page. When at the FAQ page, click to access the "Topics" drop-down menu. Choose the "Coordination of Benefits" or "Medicare Secondary Payer" option, then click on the "Search" button to find all related questions; and
- An e-mail address that can be used to submit MSP questions and comments to CMS at mspcentral@cms.hhs.gov.

DISCONTINUING SERVICES

In many situations where providers must discontinue or deny services, the patient has a right to receive written notification as to the reason the services are no longer going to be furnished or expected to be paid for by Medicare.

PROVIDING AN ADVANCE BENEFICIARY NOTICE (ABN)

Whenever a provider believes that the service/item he or she is providing may not be covered by Medicare as medically reasonable and necessary or one of several other denial reasons (see Note below), he or she should provide the patient with an acceptable ABN of Medicare's likely denial of payment. If the provider does not provide the patient with an ABN, it generally cannot hold the patient financially liable for the service/item if Medicare denies payment. Patients must be notified that payment might be denied or reduced before the service is rendered. The patient may then decide if he or she wants the service and is willing to pay for it. If the provider properly notifies the patient in advance that payment for the service may be denied or reduced, the provider is not held financially liable for the services and may seek payment from the patient if Medicare denies payment.

Written Advance Notice Information
Additional information regarding providing written advanced notice to patients that Medicare may not or will not pay for the services suggested by the providers can be found at http://www.cms.hhs.gov/medicare/bni/ on the Web.

Note: Financial Liability Protections (FLPs) apply solely to denials of Medicare payment on the basis of one of the statutory exclusions that, by law, trigger FLPs. Following is the complete list of exclusions that trigger FLPs and require an ABN:

- §1862(a)(1) - "medical necessity" exclusion denials per Limitation on Liability (LOL) §1879(a)-(g) and per Refund Requirement (RR) §1842(l) and §1834(j)(4).
- §1862(a)(9) - "custodial care" exclusion denials - per LOL §1879(a)-(g).
- §1814(a)(2)(C) and §1835(a)(2)(A) - homebound and intermittent home health care denials - per LOL §1879(g)(1).
- §1861(dd)(3)(A) - denials because the beneficiary in hospice is found not to be terminally ill - per LOL §1879(g)(2).
- §1834(a)(17)FIRST(B) - prohibited telephone solicitations ("cold calls") DME denials - per RR.

- §1834(j)(1) - failure to have a supplier number DMEPOS denials - per RR.
- §1834(a)(15) - payment denied in advance (advance coverage determination) DME denials - per RR.

The following ABN notice forms are approved by CMS:

- Advance Beneficiary Notice (Form CMS-R-131);
- Home Health Advance Beneficiary Notice (HHABN) (Form CMS-R-296);
- Hospital-Issued Notice of Non-Coverage (HINN) (Form CMS-10092); and
- SNF Notice of Non-Coverage (NONC) (Form CMS-10055).

Beneficiaries Notification Initiative Information

Information about the Beneficiaries Notification Initiative and all of the current ABN forms can be accessed at http://www.cms.hhs.gov/BNI on the CMS website.

Instructions for Completing ABNs

The Medicare program instructions for ABNs are included within Chapter 30 of the *Medicare Claims Processing Manual*, available at http://www.cms.hhs.gov/manuals/10M/list.asp on the CMS website.

SPECIFIC CRITERIA FOR THE ABN

An acceptable ABN for the denial or reduction of payment must meet the following criteria:

- The notice must be given in writing, in advance of providing the service/item (where a standard form is mandatory, notice must be given using the standard form);
- The notice must include the patient's name, description of service/item, and reason(s) the service/item may not be paid for by Medicare; and
- The patient or authorized representative must sign and date the ABN before a service is rendered, indicating that the patient assumes financial liability for the service/item if payment is denied or reduced for the reasons indicated on the ABN.

ABN FOR SERVICES PROVIDED PER REFERRAL OR ORDER OF ANOTHER PHYSICIAN

Providers must be aware of the coverage requirements for the services they provide (if they have been made available) to a patient based on a referral or order of a physician. In most cases, the availability of the coverage requirements indicates that the provider knew, or should have known, that payment for the item/service might be denied or reduced.

For services ordered by another physician (e.g., diagnostic tests), the provider who ordered the services may provide the ABN, but is not required to do so. The provider actually furnishing the services is responsible for beneficiary notification and can be held financially liable for the services if payment is denied or reduced. Also, the provider furnishing the services may be required to produce a copy of the ABN. In addition, if the ABN is considered unacceptable, the provider furnishing the services will be financially liable for those services.

For services provided based on the referral of a physician, the provider furnishing the service is in the best position to determine the likelihood of denial or reduction of payment and, therefore, should provide a proper ABN to the patient.

ABN MODIFIERS

Modifiers were developed to allow practitioners and suppliers to bill Medicare for items and services that are statutorily not covered or do not meet the definition of a Medicare benefit, and items and services not considered reasonable

and necessary by Medicare. The modifiers are used for services billed and for items and supplies billed to DMERCs. Table 3-3 provides and describes the modifier codes used for both carrier and DMERC claims.

Assigned or non-assigned claims billed to Medicare Part B must contain the "GA" modifier next to each applicable service for which the proper ABN has been given to, and signed by, the patient. The ABN form does not need to be submitted with the claim, but a copy of the signed document must be maintained (e.g., within the patient's medical records).

When DMERC claims are being filed, the "GA" and "GZ" modifiers should be used with the appropriate Healthcare Common Procedure Coding System (HCPCS) code whenever one is available. This alphanumeric code is used to describe the Durable Medical Equipment (DME) provided to the beneficiary. In cases where there is no specific HCPCS code available to describe the DME, the "A9270" HCPCS code must be used by suppliers to bill for statutorily not covered items and items that do not meet the definitions of a Medicare benefit.

Latest HCPCS Codes
The most recently posted HCPCS codes are available at http://www.cms.hhs.gov/HCPCSReleaseCodeSets on the CMS website.

PROVIDING A NOTICE OF EXCLUSIONS FROM MEDICARE BENEFITS (NEMB) - FORM CMS-20007

The NEMB may be used to advise beneficiaries that Medicare will not pay for particular items or services that are not Medicare benefits, before the items are furnished. NEMBs allow beneficiaries to make informed consumer decisions about receiving items or services for which they must pay out-of-pocket and to be more active participants in their own health care treatment decisions. Whenever it is inappropriate to use an ABN, the NEMB may be voluntarily used by physicians, practitioners, suppliers, and providers to advise their Medicare patients of the services that Medicare never covers.

Physicians, practitioners, suppliers, and providers may use notices of their own design, rather than use an already approved NEMB form. Some professional associations, with the assistance and approval of CMS, have developed service-specific NEMB-type notices to advise Medicare beneficiaries of the limits of Medicare coverage for certain items and

CMS-Approved NEMB Forms
NEMB forms that have been approved by CMS are accessible at http://www.cms.hhs.gov/BNI on the CMS website.

Table 3-3. ABN Modifiers for Carrier or DMERC Claims.

Modifier	Explanation of Use
GA	Indicates that the physician, practitioner, or supplier expects Medicare to deny item or service and they do have an ABN signed by the beneficiary on file.
GY	Indicates that the physician, practitioner, or supplier deems the item or service to be statutorily excluded or not meeting the definition of any Medicare benefit, therefore it is non-covered or is not a Medicare benefit.
GZ	Indicates that the physician, practitioner, or supplier expects the item or service to be denied in a case where an ABN would be appropriate and they do not have an ABN signed by the beneficiary on file.

services. These service-specific notices are not government notices; they are considered proprietary notices of the authoring associations.

SPECIAL CONSIDERATIONS FOR SUBMITTING DME SUPPLIER CLAIMS TO A DMERC

DME is covered under Medicare Part B insurance and defined as equipment that can withstand repeated use, is primarily used for a medical purpose, and is generally not used in the absence of illness or injury. Suppliers submit DME claims to a DMERC who will process a DME claim based on a written order submitted by a supplier. Prior to submitting a claim to the DMERC, the supplier must have the written order and a CMN (if applicable), information from the treating physician concerning the patient's diagnosis (if an ICD-9-CM code is required on the claim), and any information required for the use of specific modifiers or attestation statements as defined in certain DMERC policies.

SUBMITTING WRITTEN ORDERS WITH DME CLAIMS

Written orders are acceptable for all transactions involving DME. Written orders can be submitted as a photocopy, facsimile image, electronic file, or an original "pen-and-ink" document. The supplier must obtain a written order that meets the requirements of this section. If the written order is for supplies that will be provided on a periodic basis, the written order should include:

- The start date of the order;
- A detailed description containing all options or additional features that will be separately billed or that will require an upgraded code. The description can be either a narrative description (e.g., lightweight wheelchair base) or a brand name/model number;
  Note: Someone other than the physician may complete the detailed description of the item or service. However, the treating physician must review the detailed description and personally sign and date the order to indicate agreement.
- Appropriate information on the quantity used;
- Frequency of change;
- Indication of whether the order is a rented item, specifying the duration of need (if necessary); and
- The name of the drug, concentration level (if applicable), dosage, frequency of administration, and duration of infusion (if applicable) if the supply is a drug.

Medical necessity information (e.g., an ICD-9-CM diagnosis code, narrative description of the patient's condition, abilities, limitations, etc.) is NOT considered to be part of the order, although it may be included within the same document as the order.

A nurse practitioner or clinical nurse specialist may provide a verbal order, and then sign and date the subsequent written order in the following situations:

- He or she is treating the beneficiary for the condition for which the item is needed;
- He or she is practicing independently of a physician;
- He or she bills Medicare for other covered services using their own provider number; and
- He or she is permitted to do all of the above in the state in which services are provided.

A physician's assistant (PA) may provide a verbal order and then sign and date the subsequent written order if they satisfy the following requirements:

- He or she meets the Medicare definition of a PA (person with two or more years of advanced training who is exam-certified, works with a doctor, and can perform some of the services that a doctor can provide);
- He or she is treating the beneficiary for the condition for which the item is needed;
- He or she is practicing under the supervision of a Doctor of Medicine (DM) or Doctor of Osteopathy (DO);

- He or she has their own Unique Physician Identification Number (UPIN); and
- He or she is permitted to do all of the above in the state in which services are provided.

Example Written Order
An order for surgical dressings might specify one 4 x 4 hydrocolloid dressing that is changed 1-2 times per week for one month, or until the ulcer heals.

SUBMITTING WRITTEN DME ORDERS PRIOR TO DELIVERY

A written order prior to delivery is required for the DME items that are listed with the associated HCPCS codes in Table 3-4.

For these items, the supplier must have received a written order that has been both signed and dated by the treating physician. The written order must meet the requirements specified in Part III, Submitting Written DME Orders Prior to Delivery.

If a supplier bills for an item without a written order when the supplier is required to have a written order prior to delivery, the item will be denied for not meeting the benefit category and therefore cannot be appealed by the supplier.

Table 3-4. DME Items with Associated HCPCS Codes.

HCPCS Code	Item
Decubitus Care	
A4640	Replacement pad for use with medically necessary alternating pressure pad owned by patient
E0176	Air pressure pad or cushion, non-positioning
E0177	Water pressure pad or cushion, non-positioning
E0178	Gel pressure pad or cushion, non-positioning
E0179	Dry pressure pad or cushion, non-positioning (e.g., egg crate)
E0180	Pressure pad, alternating, with pump
E0181	Pressure pad, alternating, with pump, heavy duty
E0182	Pump for alternating pressure pad
E0184	Dry pressure mattress
E0185	Gel or gel-like pressure pad for mattress, standard mattress length and width
E0186	Air pressure mattress
E0187	Water pressure mattress
E0192	Low pressure and positioning equalization pad for wheelchair (for example, ROHO, Jay, etc.)
E0193	Powered air flotation bed (low air loss therapy)

HCPCS Code	Item
Decubitus Care (Con't)	
E0194	Air-fluidized bed
E0196	Gel pressure mattress
E0197	Air pressure pad for mattress, standard mattress length and width
E0198	Water pressure pad for mattress, standard mattress length and width
E0199	Dry pressure pad for mattress, standard mattress length and width
E0277	Powered pressure-reducing air mattress
E0371	Non-powered advanced pressure reducing overlay for mattress, standard mattress length and width
E0372	Powered air overlay for mattress, standard mattress length and width
Seat Lift Mechanism	
E0627	Seat lift mechanism incorporated into a combination lift-chair mechanism
E0628	Separate seat lift mechanism for use with patient owned furniture-electric
E0629	Separate seat lift mechanism for use with patient owned furniture-non-electric
Transcutaneous Electrical nerve Stimulator (TENS)	
E0720	TENS, two-lead, localized stimulation
E0730	TENS, four-lead, larger area/multiple nerve stimulation
E0731	Form-fitting conductive garment for delivery of TENS or Neuromuscular Electrical Stimulator (NMES) (with conductive fibers separated from the patient's skin by layers of fabric)
Power Operated Vehicle (POV)	
E1230	Power operated vehicle (three-or four-wheel non-highway). Specify brand name and model number
Negative Pressure Wound Therapy (NPWT)	
K0538	Negative pressure wound therapy electrical pump, stationary or portable

Part 4
Protecting Medicare from Fraud and Abuse

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 (Public Law 104-191), also known as the Kassebaum-Kennedy legislation, includes a provision establishing the "Medicare Integrity Program". The primary principle of Medicare Program Integrity (PI) is to pay claims correctly. To meet this goal, contractors must ensure that they pay the right amount for covered and correctly coded services rendered to eligible beneficiaries by legitimate providers. For their part, providers must make sure they comply with the coverage and payment policies established by Congress and the Medicare Program.

The Centers for Medicare & Medicaid Services (CMS) follow four parallel strategies in meeting this goal:

- Preventing fraud through effective enrollment and through education of physicians, providers, suppliers, and beneficiaries;
- Early detection (e.g., through medical review and data analysis);
- Close coordination with partners, including contractors and law enforcement agencies; and
- Fair and firm enforcement policies.

Most provider billing errors are not an attempt to knowingly, willfully, or intentionally commit fraud. For example, some errors are the result of provider misunderstanding or a failure to pay adequate attention to Medicare policy. However, other errors are a result of calculated plans to knowingly commit fraud for unjustified payment. When errors are identified, Medicare will take action commensurate with the error made. The agencies responsible for protecting Medicare will evaluate the circumstances surrounding the error and proceed with the appropriate plan of correction.

In rare situations where a provider has repeatedly submitted claims in error or has demonstrated gross disregard for Medicare conditions of participation, coverage, and payment policy, Medicare will seek legal action against the individual and/or organization. Medicare utilizes both medical review (MR) and fraud investigation data analysis to detect potential payment errors. The results identified by data analysis determine whether a situation is an error (pursued by the MR unit), potentially fraudulent (pursued by fraud investigators), or neither. Investigations may also be initiated by reports of improper activities reported by individuals, also referred to as "whistle blowers".

This section identifies the coordinated activities and explains the differences in the purpose, functions, and requirements of MR and fraud investigations in assuring correct initial Medicare payment. This background information will help the provider to identify and establish procedures to correctly code and submit claims for covered services that were rendered to eligible beneficiaries.

WHAT IS MEDICAL REVIEW (MR)?

All Medicare contractors are required to ensure that reimbursement is made only for those services that are reasonable and necessary. For medically necessary services, the contractor is also responsible for ensuring that services are rendered in the most cost-effective manner (i.e., consideration is given to the location of service and the complexity and level of care provided).

For Medicare to ensure that payment is made only for reasonable and necessary services, each Medicare contractor is required to perform extensive data analysis on the frequency a service is allowed. The focus is on how providers or suppliers and their services are trended and what Medicare does through the MR process when coverage and utilization problems are identified, resulting in various plans of action to correct the problem.

BENEFITS TO MEDICARE PROVIDERS AND SUPPLIERS

MR initiatives are designed to apply national payment criteria, to define Medicare coverage of medical care through the development of medical policy, and to ensure that Local Medical Review Policies (LMRPs) and review guidelines are consistent with accepted medical practice standards. The MR process provides the following benefits:

- **Decreased denials** - Knowledge of appropriate claims guidelines can result in a reduction in filing errors and an increase in more timely payments.
- **Improvement in the way Medicare reviews cases** - Development of LMRPs provide guidelines for the decision-making process.
- **Reduced claim reviews** - Because providers and suppliers have a better understanding of when and what Medicare needs to support a service as it relates to claim documentation, the claim filing process is smoother and faster.
- **Predictability in claim decisions** - Because local contractor policies are made available to all eligible providers and suppliers through contractor publications and websites, there is less “guess work” on behalf of the provider or supplier when furnishing information to support medical necessity.
- **Emphasis on education** - Medicare offers educational opportunities through comprehensive articles and contractor-sponsored educational training events.
- **Increased program integrity** - The Medicare Integrity Program helps to ensure that Medicare claims are correctly paid.

PROGRESSIVE CORRECTIVE ACTION (PCA)

MR PCA is a concept designed by CMS for Medicare contractors to use when deploying resources and tools to conduct MRs. PCA ensures that MR activities are targeted at identified problem areas and that imposed corrective actions are appropriate for the severity of the infraction of Medicare rules and regulations. The following four types of corrective actions can result from MR evaluations:

- Education;
- Policy development;
- Prepayment review; and
- Postpayment review.

HOW PCA WORKS

The decision to conduct MR is driven by data analysis. Data analysis is the first step in PCA for determining unusual or unexpected billing patterns that might suggest improper billing or payment. The data analysis may be general surveillance, or may be specific in response to complaints or reports from various agencies.

The second step in PCA is validating the hypothesis of the data analysis. Before assigning significant resources to examine claims identified as potential problems, probe reviews are conducted. A probe review generally does not exceed 20-40 claims per provider for provider-specific problems, and does not exceed 100 claims distributed among the identified provider community for general, widespread problems. All providers subject to a probe review are notified in writing that a probe review is being conducted, and are also notified in writing of the results of the review. Providers are asked to provide any and all medical documentation applicable to the claims in question.

WHAT PCA ACCOMPLISHES

The probe review step in PCA results in classification of a detected problem, if applicable. There are three classification levels of problems:

- Minor;
- Moderate; or
- Major.

The classification level of a detected problem is determined according to the:

- Provider-specific error rate (number of claims paid in error);
- Dollar amounts improperly paid; and
- Past billing history.

If a minor problem is detected, the Medicare contractor will:

- Educate the provider on appropriate billing procedures;
- Collect the money on claims paid in error; and
- Conduct further analysis at a later date to ensure that the problem was corrected.

If a moderate problem is detected, the contractor will:

- Educate the provider on appropriate billing procedures;
- Collect the money on the claims paid in error; and
- Initiate some level of prepayment MR until the provider demonstrates that they have corrected their billing procedures.

If a major problem is detected, the contractor will:

- Educate the provider on appropriate billing procedures;
- Collect the money on the claims paid in error; and
- Initiate a high level of prepayment medical review and/or a statistically valid random sample (SVRS), payment suspension, and/or referral to the contractor's Benefit Integrity Department (as appropriate).

WHAT TYPES OF CORRECTIVE ACTION ARE AVAILABLE?

There are various types of corrective actions that can be taken in the event a problem is discovered during the PCA process. Actions will be taken according to the classification of the problem, as appropriate. Possible actions that could be taken include:

- Development of provider education and feedback;
- Development of local policy;
- Performance of prepayment review;
- Performance of postpayment review; or
- Performance of proactive measures related to MR records requests.

PROVIDER EDUCATION AND FEEDBACK

Along with the planned MR activities, provider or supplier feedback and education developed according to the review findings are an essential part of the PCA process. When individual reviews are conducted, focused provider education is carried out through direct contact between the Medicare contractor and the provider via telephone, letter, and/or face-to-face contact. The overall goal of providing feedback and focused provider education is to ensure development of proper billing practices. This will ensure that claims will be submitted and paid correctly because the provider understands what to expect when a claim is submitted to Medicare.

LOCAL POLICY DEVELOPMENT

The MR process is conducted in accordance with both national and local policies that are the foundation of the review process. The primary authority for all coverage provisions and subsequent policies is the Social Security Act. Contractors use Medicare policies in the form of regulations, national coverage decisions (NCDs), coverage provisions in interpretive manuals, and LMRPs to apply the provisions of the Social Security Act.

NATIONAL COVERAGE DECISIONS (NCDS)

NCDs are developed by CMS to describe the circumstances for Medicare coverage for a specific medical service procedure or device. NCDs generally outline the conditions for which a service is considered to be covered (or not covered) under §1862(a)(1) of the Social Security Act or its applicable provisions. These policies are usually issued as a CMS program instruction. Once published in a CMS program instruction, an NCD is binding on all Medicare contractors and providers or suppliers. NCDs made under §1862(a)(1) of the Social Security Act are also binding on Administrative Law Judges (ALJs) during the claim appeal process. For additional information on ALJ review, please refer to Part V, How to Request a Part B ALJ Hearing.

List of Current NCDs
Current NCDs are available at http://www.cms.hhs.gov/mcdindexes.asp on the CMS website.

Within 30 calendar days after an NCD is issued by CMS, contractors will either publish the NCD on their contractor website or link to the NCD posted on the CMS website from their contractor website. In addition, the NCD will be included, as soon as possible, within a provider bulletin.

NCDs should not be confused with coverage provisions in interpretive manuals, which are discussed in the following section.

COVERAGE PROVISIONS IN INTERPRETIVE MANUALS

Coverage provisions in interpretive manuals are coverage instructions published by CMS that are not considered NCDs [see Part 4, National Coverage Decisions (NCDS)]. These instructions are used to further define when services may be covered or not covered under Medicare. Once published, the coverage provision in an interpretive manual is binding on all Medicare contractors and providers.

Within 30 calendar days of the new provision being issued by CMS, contractors will either publish the coverage provision on their contractor website or link to the coverage provision posted on the CMS website from their contractor website. In addition, the coverage provision will be included, as soon as possible, within a provider bulletin.

LOCAL MEDICAL REVIEW POLICY (LMRP)

An LMRP is a formal statement developed through a specifically-defined process that:

- Defines the service;
- Provides information about when the service is considered reasonable and necessary;

- ❖ Outlines any coverage criteria and/or specific documentation requirements;
- ❖ Provides specific coding and/or modifier information; and
- ❖ Provides references upon which the policy is based.

Generally, an LMRP is an administrative and educational tool used to assist providers and suppliers in submitting correct claims for payment, and to guide medical reviewers. LMRPs specify under what clinical circumstances a service is covered (including under what clinical circumstances it is considered to be reasonable and necessary) and correctly coded. LMRPs outline how contractors will review claims to ensure that they meet Medicare coverage and coding requirements. The contractor may adopt LMRPs that have been developed individually or collaboratively with other contractors. The contractor shall ensure that all LMRPs are consistent with all statutes, rulings, regulations, and national coverage, payment, and coding policies.

LMRP Format Standards
The standardized format required for all new LMRPs may be found within Exhibit 6 of the *Medicare Program Integrity Manual* which is available at http://www.cms.hhs.gov/manuals/IOM/list.asp on the CMS website.

Access to LMRPs
Copies of Draft and Final versions of LMRPs are available within the Medicare Coverage Database located at http://www.cms.hhs.gov/cd/Search.asp on the CS website.

Once developed and implemented, LMRPs provide the decision-making criteria for claim review and payment decisions. A major part of the process that defines an LMRP includes a review by a Carrier Advisory Committee (CAC) comprised of medical professionals within both the Medicare Program and the medical community. This review process also allows for other medical professionals throughout the state to comment on proposed policies prior to finalization, thus assuring an objective review of the policy. If a contractor develops an LMRP, its LMRP applies only within the geographic area that contractor services. While another contractor may come to a similar LMRP decision, CMS does not require that contractor to adopt an LMRP of the first contractor.

According to CMS requirements, all LMRPs are published and distributed to providers through local Medicare contractor news bulletins, publications, and the CMS website. Because the contractor provides this information to practitioners and facilities, it is understood that providers and their employees will be responsible for reading and knowing the information. These publications should be kept and used as ongoing references and instructional guides when billing Medicare. In some cases, if the contractor can determine that the provider knew, or should have known, the proper way to bill or utilize proper coding techniques, etc., the improper billing may be determined to be a willful or fraudulent act.

PREPAYMENT REVIEW

Prepayment review consists of MR of a claim prior to payment. This type of review may require submission of medical records and includes automated, routine, and complex activities. Prepayment review may affect any provider.

AUTOMATED PREPAYMENT REVIEW

When prepayment review is automated, decisions are made at the system level using available electronic information, without the intervention of contractor personnel. Automated editing allows the contractor to review information submitted on the claim regarding particular procedure codes. This may consist of the following:

- ❖ Diagnosis to procedure code;
- ❖ Frequency to time;
- ❖ Place of Service (POS) to procedure code; and/or
- ❖ Specialty to procedure code.

ROUTINE PREPAYMENT REVIEW

Routine prepayment review requires the intervention of specially trained MR staff. An intervention can occur at any point in the review process. For example, a claim may be suspended for routine review because an MR determination cannot be automated. Routine review requires hands-on review of the claim and/or any attachment submitted by the provider (other than medical records) and/or claims history file and/or internal MR guidelines.

COMPLEX PREPAYMENT REVIEW

Complex review goes beyond the routine review process to include the evaluation of medical records or other documentation that requires professional medical expertise. This may include ambulance trip reports for the purpose of preventing or identifying payments of non-covered or incorrectly coded services, as well as other types of medical documentation. This type of review involves the evaluation of medical records and may only be performed by a clinician reviewer (e.g., a nurse, a physician, or other qualified clinician).

Prepayment Edits

Prepayment edits are designed by contractor staff and put in place to prevent payment for non-covered and/or incorrectly coded services. These edits are also used to select targeted claims for review prior to payment. MR edit development is the creation of logic (i.e., the edit) that is used during claim processing prior to payment that validates and/or compares data element values on the claim.

Service-Specific Edits

Service-specific edits select claims containing specific services for review. They may compare two or more data element values present on the same claim (e.g., diagnosis to procedure code), or they may compare one or more data element values on a claim with data from the beneficiary's history file (e.g., procedure code compared to history file to determine frequency in the past 12 months).

Provider-Specific Edits

Provider-specific edits select claims from specific providers that are flagged for review. These providers are singled out due to unusual practice patterns, knowledge of service area abuses, and/or utilization complaints received from beneficiaries or others. These edits can suspend all claims from a particular provider or supplier, or place focus on selected services, POSs, etc.

Provider-Specific Review

A provider-specific review may include certain procedures or all claims from a particular provider. This review requires submission of documentation and results in either an educational intervention by the contractor or further corrective actions. Providers are notified that documentation submission is required. If a provider is placed on prepayment review, the procedure codes are contingent upon the scope of the problem identified.

POSTPAYMENT REVIEW

Postpayment review involves MR of a claim after payment has been made. This type of review includes:

probe review of an individual provider;
- A widespread probe; and
- An SVRS.

This type of review always requires the submission of medical documentation for review.

INDIVIDUAL PROVIDER PROBE REVIEW

When an individual provider is identified on a prepayment or postpayment basis as being statistically different from peers, a probe review is conducted. A small number of claims (approximately 20-40) are identified and a letter is sent to the provider requesting medical documentation to support those claims. Once

the documentation is received, it is reviewed to determine if the claims were documented as having been performed, coded correctly, reasonable and necessary, and a covered Medicare benefit. The provider will be notified, in writing, of the review results. The next steps in the process are dependent upon the results of the review and may include no action, collection of money paid in error, physician education, referral to prepayment flag, or an SVRS.

WIDESPREAD PROBE REVIEW

If a widespread problem is identified, approximately 100 claims are reviewed. An example of such a problem would be an overall spike in billing for a procedure or diagnosis code. A few claims (approximately 5-10) will be requested from several individual providers who have been billing the code in question. The results of this review will determine if:

- Widespread provider education is appropriate;
- Collection of money paid in error is needed;
- A policy needs to be developed;
- An existing policy needs to be revised; or
- System prepayment edits or audits need to be implemented.

STATISTICALLY VALID RANDOM SAMPLE (SVRS)

An SVRS is an in-depth audit of a provider's utilization, coding, and documentation practices. It is used after problems with a provider's utilization pattern have been validated through a probe review. This type of review will result in one or more of the following actions:

- Provider education;
- An overpayment request (possibly projected to the provider's community); or
- A prepayment MR.

If continued non-compliance is demonstrated despite documented educational interventions, a referral may be made to the Benefit Integrity Department for investigation and possible suspension.

PROACTIVE MEASURES RELATED TO MR RECORDS REQUESTS

The purpose of MR is to assist the medical community in the reimbursement of covered medical care with a minimum of inconvenience and dollar expenditure. The following are some measures that providers can take to help avoid any negative impact associated with the MR process:

- Review and read all contractor publications, including LMRPs, and become knowledgeable about the coverage requirements;
- Ensure that office staff and billing vendors are familiar with claim filing rules associated with any LMRP that affects a provider setting or specialty;
- Check records against claims billed;
- Create an educational awareness campaign for Medicare patients that helps them understand any specific coverage limitations or medical necessity requirements for those services provided;
- Work with claim submission vendors to incorporate LMRP edits; and
- Perform mock record audits to ensure that documentation reflects the requirements outlined in the LMRP.

SUBMITTING DOCUMENTATION FOR MR REVIEW

To perform an effective MR of services rendered by a provider, it may be necessary for the provider to furnish specific documentation upon request by the contractor. The following points about submitting documentation should be kept in mind:

- Every service billed must be documented since there must be clear evidence in the patient's record that the service, procedure, or supply was actually performed or supplied;
- The medical necessity for choosing the procedure, service, or medical supply must be substantiated;

- Every service must be coded correctly. Diagnoses must be coded to the highest level of specificity, and procedure codes must be current;
- The documentation must clearly indicate who performed the procedure or supplied the equipment;
- Although it may be dictated and transcribed, legible documentation is required. Existing documentation may not be embellished (e.g., adding what was omitted in the initial documentation), however, additional documentation that supports a claim may be submitted; and
- Voluntary disclosure of information by the provider is encouraged. When an error is discovered, any overpayments should be returned to Medicare.

Occasionally, documentation is requested through the contractor's Additional Development Request (ADR) letter. The contractor may also request documentation either during a data-driven review, or when the provider contests a denial determination, by requesting a review of the claim. Examples of documentation needed for MR of provider services could include, but are not limited to:

- Office records including progress notes, a current history and physical, and a treatment plan;
- Documentation of the identity and professional status of the clinician;
- Laboratory and radiology reports;
- A comprehensive problem list;
- A current list of prescribed medications;
- Progress notes for each visit that demonstrates the patient's response to prescribed treatment;
- Documentation supporting the time spent with the patient when using time-based codes;
- Any required referrals or prescriptions (for many non-physician services/supplies); or
- Any required Certificates of Medical Necessity (CMNs).

Additional MR Process Information

The *Medicare Program Integrity Manual* contains additional information regarding the MR process, including how LMRPs are developed. It may be accessed at http://www.cms.hhs.gov/manuals/IOM/list.asp on the CMS website.

WHAT HAPPENS IF THE FRAUD INVESTIGATION PROCESS GOES WRONG?

Physicians, suppliers, and other providers have a legal obligation to conform to the requirements of the Medicare Program. While most individuals or organizations are honest and make every effort to adhere to the guidelines set forth in the Medicare Program, some may be dishonest. Further, the high monetary amount billed to the Medicare Program makes it vulnerable to individuals who may inappropriately administer medical and healthcare services or bill for services never rendered. CMS must take strong action to combat fraud and protect the Medicare Trust Fund. The goal is to make sure Medicare only does business with legitimate providers who will furnish Medicare beneficiaries with needed high quality services.

The effort to prevent and detect fraud is a cooperative one that involves:

- CMS;
- Medicare beneficiaries;
- Medicare contractors;
- Physicians, suppliers, and other providers;
- Quality Improvement Organizations (QIOs); and
- State and Federal law enforcement agencies such as the Office of Inspector General (OIG) of the Department of Health and Human Services (DHHS), the Federal Bureau of Investigation (FBI), and the Department of Justice (DOJ).

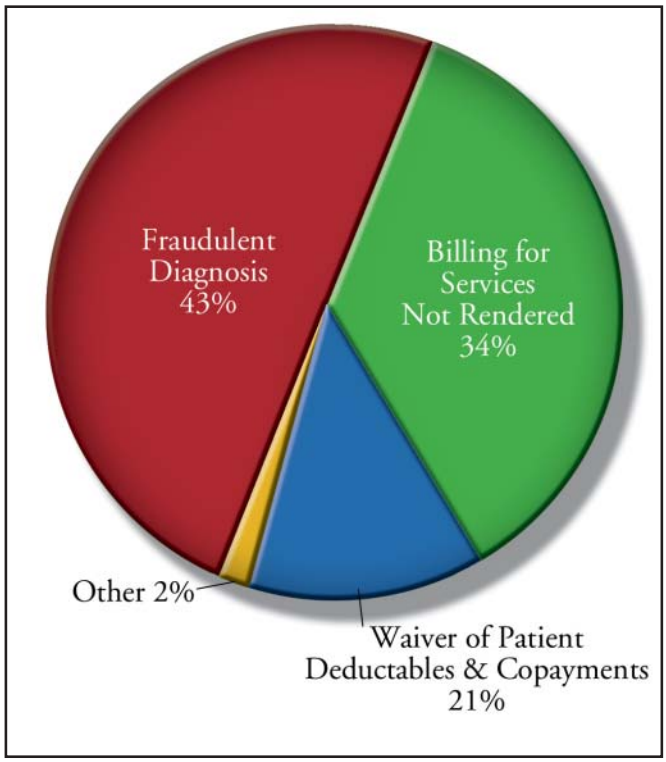
A primary role of each of these individuals/agencies is to:

- Identify cases of suspected fraud;
- Investigate suspected fraud cases thoroughly and in a timely manner; and
- Take immediate action to ensure that Medicare Trust Fund dollars are not inappropriately paid out and that any payments made in error are recouped.

Suspension and denial of payments and the recoupment of overpayments are only some of the possible actions. When appropriate, cases are referred to the OIG Office of Investigations Field Office for consideration of criminal actions, and initiation of civil monetary penalties or administrative sanction.

The most frequent kind of fraud arises from a false statement or misrepresentation made, or caused to be made, that is material to entitlement or payment under the Medicare Program. Figure 4-1 shows a numerical breakdown of the most common fraudulent activities by violators. The violator may be a provider, beneficiary, physician or other practitioner, supplier of durable medical equipment (DME), an employee of a physician or practitioner, or some other person or business entity including a billing service or a contractor employee.

Figure 4-1. Breakdown of Common Fraudulent Activities.



Fraud committed against the program may be prosecuted under various provisions of U.S. Code and could result in the imposition of restitution, fines, and possibly imprisonment. In addition, there is also a range of administrative sanctions (i.e., exclusion from participation in the program) and civil monetary penalties that may be imposed when facts and circumstances warrant such action.

Individuals or organizations identified as engaging in potentially inappropriate activities are not subject to automatic prosecution. Stewards of the Medicare Program (i.e., the Federal Government, its agencies, and its contractors) are required to be prudent and treat physicians, suppliers, and other providers fairly when making decisions that will affect them or their organizations.

Investigation and prosecution of healthcare fraud are reserved for willful and intentional acts of wrongdoing, substantiated through documented inappropriate billing patterns. To address other inappropriate activities or payments, “safeguard” measures, rather than punitive measures, may be taken.

WHAT CONSTITUTES FRAUD

Fraud occurs when an individual intentionally deceives or misrepresents the truth, knowing that it could result in some unauthorized benefit to himself or herself, or some other person. The violator may be a physician or other practitioner, a hospital or other institutional provider, a clinical laboratory or other supplier, an employee of any provider, a billing service, a beneficiary, a Medicare contractor employee, or any person in a position to file a claim for Medicare benefits.
Fraud schemes range from those perpetrated by individuals acting alone to broad-based activities by institutions or groups of individuals, sometimes employing sophisticated telemarketing and other promotional techniques

to lure consumers into serving as the unwitting tools in the schemes. Seldom do perpetrators target only one insurer or either the public or private sector exclusively. Rather, most are simultaneously defrauding several private and public sector victims, such as Medicare.

According to a 1993 survey by the Health Insurance Association of America of private insurers' healthcare fraud investigations, overall healthcare fraud activity could be broken down as follows:

EXAMPLES OF FRAUD

Fraud may take such forms as:

- Incorrect reporting of diagnoses or procedures to maximize payments;
- Billing for services not furnished and/or supplies not provided. This includes billing Medicare for appointments that the patient failed to keep;
- Billing that appears to be a deliberate application for duplicate payment for the same services or supplies, billing both Medicare and the beneficiary for the same service or billing both Medicare and another insurer in an attempt to get paid twice;
- Altering claim forms, electronic claim records, medical documentation, etc., to obtain a higher payment amount;
- Soliciting, offering, or receiving a kickback, bribe, or rebate (e.g., paying for a referral of patients in exchange for the ordering of diagnostic tests and other services or medical equipment);
- Unbundling or “exploding” charges;
- Completing Certificates of Medical Necessity (CMNs) for patients not personally and professionally known by the provider or supplier;
- Billing based on “gang visits” (e.g., a physician visits a nursing home and bills for 20 nursing home visits without furnishing any specific service to individual patients);
- Misrepresentations of dates and descriptions of services furnished or the identity of the beneficiary or the individual who furnished the services;
- Billing non-covered or non-chargeable services as covered items; and
- Using another person's Medicare card to obtain medical care.

Examples of cost report fraud may include:

- Incorrectly apportioning costs on cost reports;
- Including costs of non-covered services, supplies, or equipment in allowable costs;
- Arrangements by providers or suppliers with employees, independent contractors, suppliers, and others that appear to be designed primarily to overcharge the program through various devices (commissions, fee splitting) to siphon off or conceal illegal profits;
- Billing Medicare for costs not incurred, or costs that were attributable to non-program activities, other enterprises, or personal expenses;
- Claiming bad debts without first genuinely attempting to collect payment;
- Amounts paid to owners or administrators that have been determined to be excessive in prior cost report settlements;
- Days that have been improperly reported and would result in an overpayment if not adjusted;
- Program data where provider or supplier program amounts cannot be supported; and
- Allocation of costs to related organizations that have been determined to be improper.

WHAT CONSTITUTES ABUSE

Abuse describes practices that either directly or indirectly result in unnecessary costs to the Medicare Program. Many times abuse appears quite similar to fraud except that it is not possible to establish that abusive acts were committed knowingly, willfully, and intentionally. Although these types of practices may initially be categorized as abusive in nature, under certain circumstances they may develop into fraud if there is evidence that the subject was knowingly and willfully conducting an abusive practice.

EXAMPLES OF ABUSE

The following are examples of abuse:

- Charging in excess for services or supplies;
- Providing medically unnecessary services;
- Providing services that do not meet professionally recognized standards;
- Billing Medicare based on a higher Fee Schedule than is used for patients not on Medicare;
- Submitting bills to Medicare that are the responsibility of other insurers under the Medicare Secondary Payer (MSP) regulations;
- Violating the participating physician/supplier agreement with Medicare or Medicaid;
- Breaches of the assignment agreement; or
- Violating the Maximum Allowable Actual Charge Limits or the limitation amount.

FRAUD AND ABUSE CASE EXAMPLES

The following are some actions the Federal Government took in actual cases involving Medicare providers or suppliers:

- In Illinois, a former owner of an ambulance service was sentenced to 27 months imprisonment and ordered to pay $600,000 in restitution for healthcare fraud. The man submitted claims for transports that were medically unnecessary. In addition, ambulance run records were altered to add services that were not provided to patients.

- In Florida, a man in control of several DME corporations was sentenced to 84 months in prison and ordered to pay $14.4 million in restitution for his role in schemes to defraud Medicare and Medicaid. In addition, the court ordered a $14.8 million order of forfeiture against him. The man previously pled guilty on behalf of six DME corporations that were set up to launder money. Despite a temporary restraining order, the man and his co-conspirators continued to fraudulently bill Medicare and launder the proceeds of the fraud through offshore bank accounts.

- In addition, a co-conspirator was sentenced to one year and one day in prison and ordered to pay $474,000 in restitution for conspiracy and submitting false claims. The sales representative received commissions from the sale of motorized wheelchairs, alternating pressure mattresses, and related items. Another sales representative was ordered to pay $485,000 in restitution for conspiracy and submitting false claims to Medicare and Medicaid. The man received and distributed commission payments for other sales representatives working under his direction.

- A New York couple who owned a DME company was sentenced based on their guilty pleas. The husband was sentenced to 15 months incarceration and ordered to pay $210,000 in restitution for healthcare fraud. His wife was sentenced to six months in a halfway house and six months home detention for paying kickbacks to doctors. Although the owners and their staff provided Medicare and Medicaid beneficiaries with inexpensive soft back braces, they actually billed Medicare for expensive, firm body jackets. The wife provided the funding that was used to pay kickbacks to doctors for their referrals and prescriptions.

- In Massachusetts, a physician was ordered to pay a $5,000 fine for conspiring to receive kickbacks from a pharmaceutical company. The physician conspired with a sales representative from the company to receive free samples of the prostate cancer drug, Lupron Depot, in return for his decision to switch his patients from another drug to Lupron. The physician, who received 30 free samples, not only switched patients to the drug, but also billed Medicare for the free samples.

- A Pennsylvania podiatrist was sentenced to 12 months and one day of imprisonment and ordered to pay $409,000 in fines and restitution. The podiatrist previously pled guilty to false statements relating to healthcare matters. During a 6-year

period, the podiatrist billed Medicare for more than 20,000 nail avulsion surgical procedures when in fact the number was significantly lower.

- A New York physician was sentenced to six months imprisonment and ordered to pay $250,000 in restitution for healthcare fraud. The owner of a clinic billed Medicare using the physician's Medicare provider number. In return for the use of his provider number, the owner of the clinic paid the physician $2,500 a month and let him utilize office space and billing staff at the clinic. As a result, the owner received payments from Medicare for physical therapy services he was not qualified or legally allowed to perform and for services that were not provided.

- In New York, an individual practitioner was ordered to pay a $30,000 fine for violating the anti-kickback statute. The doctor received kickback payments from a medical supply company, an MRI center, and a laboratory.

- In Missouri, six co-defendants were sentenced for conspiring to defraud the U.S. through a system of kickbacks for patient referrals and the filing of false claims that resulted in overpayments from Medicare and Medicaid. The individuals sentenced included a licensed medical doctor, a registered nurse, a billing service owner, an employee who provided medical billing services, and two owners of several residential care facilities and Home Health Agencies (HHAs). The six were ordered to pay respective restitution amounts totaling $526,000 and four were sentenced to prison. One central aspect of the scheme involved the owners' referral of patients from their residential facilities to doctors in exchange for them to certify the patients as homebound and eligible for their home health services. This arrangement allowed the doctors to bill Medicare and Medicaid for patient visits and the HHAs to bill Medicare and Medicaid for providing home health services.

MEDICARE INCENTIVE REWARD PROGRAM (IRP)

Section 203(b)(1) of HIPAA (Public Law 104-191), established the Medicare IRP to encourage individuals to report information on individuals and entities that are engaged in or have engaged in acts or omissions that constitute grounds for the imposition of a sanction under Sections 1128, 1128A, or 1128B of the Social Security Act, or who have otherwise engaged in sanctionable fraud and abuse against the Medicare Program under Title XVIII of the Social Security Act.

The Medicare IRP pays an incentive reward to individuals who provide information on Medicare fraud and abuse or other sanctionable activities. The Medicare Program will make a monetary reward for information that leads to a minimum recovery of $100 of Medicare funds from individuals and entities determined by CMS to have committed sanctionable offenses. Only referrals from fiscal intermediaries (FIs) and carriers to OIG, made pursuant to the criteria set forth in Chapter 3, Section 10, of the *Medicare Program Integrity Manual* are considered sanctionable for the purpose of the Medicare IRP.

Obtaining Medicare IRP Information
Additional information regarding the Medicare IRP is available at http://www.cms.gov/manuals/IOM/list.asp on the CMS website.

Report or Ask Questions about Fraud and Abuse
To ask questions about fraud and abuse or to report suspected fraudulent or abusive activities, providers are encouraged to contact their Medicare contractor or call the national DHHS/OIG Hot Line directly at 1-800-HHS-TIPS.

Specific criteria inform Medicare contractors that they have a duty to identify cases of suspected fraud and to make referrals of all such cases to OIG, regardless of dollar thresholds or subject

matter. Matters should be referred when the contractor has a reasonable basis to suspect that the provider:

- Intentionally engaged in improper billing;
- Submitted improper claims with actual knowledge of their falsity; or
- Submitted improper claims with reckless disregard or deliberate ignorance of their truth or falsity.

In cases where providers' employees submit complaints, such cases should be forwarded to OIG immediately. The amount of the reward will not exceed 10% of the overpayment recovered in the case, or $1,000, whichever is less. Collected fines and penalties are not included as part of the recovered money for purposes of calculating the reward amount.

PREPAYMENT AND POSTPAYMENT REVIEW

Medicare contractors have a responsibility to ensure that claim payments are made appropriately. One way to do this is to review claims and medical records on either a prepayment or postpayment basis. Medicare may ask the physician and/or supplier to submit documentation for a detailed review of targeted claims. After the review, payment may be allowed, denied, or reduced.

If fraud is suspected or continued non-compliance with Medicare requirements is demonstrated, despite documented educational interventions, a referral to the Benefit Integrity Department of the Medicare contractor may be made for investigation and possible payment suspension.

OVERPAYMENTS

Overpayments are Medicare funds a provider or beneficiary has received in excess of amounts due and payable under the Medicare statute and regulations. Once it has been determined an overpayment has been made, the amount of the overpayment is a debt owed to the Federal Government. Federal law strictly requires CMS to seek recovery of overpayments, regardless of how an overpayment is identified or caused, including when an overpayment is CMS' mistake.

Medicare strives to ensure payment accuracy; however, mistakes occasionally occur. Providers are responsible for making voluntary refunds to Medicare when they identify an overpayment. Additionally, providers are also responsible for timely repayment when Medicare notifies them of an overpayment. If a timely repayment is not made after proper notice, interest will accrue at an annual rate specified by law on the outstanding balance. Finally, penalties may be imposed on overpaid monies, depending on the circumstances involved in the case. Part B overpayments must be returned to the local Medicare carrier; physicians, suppliers, and other providers must not keep incorrect payments. These overpayments may often require the refund of copayments made by or on behalf of beneficiaries.

Providers who may have questions related to a Medicare overpayment and/or other Medicare debt collection should call the local Medicare contractor's toll-free customer service number for assistance.

ADMINISTRATIVE SANCTIONS

If CMS determines the existence of inappropriate and/or fraudulent behavior on the part of a contractor, various administrative sanctions could be taken to address the issue. Possible sanctions that could be taken include:

- Denial or revocation of an application for a provider number;
- Suspension of payments to a provider; or
- Application of civil monetary penalties.

DENIAL OR REVOCATION OF PROVIDER NUMBER APPLICATION

CMS has the authority to deny or revoke an individual's or organization's application for a Medicare provider number if there is evidence of impropriety (e.g., previous convictions, false information on the application) or if the provider

does not meet State/Federal licensure or certification requirements.

If changes have occurred to information on original applications for Medicare provider numbers, individual providers or organizations must notify the applicable Medicare contractor or state agency. Examples of such changes may include address change, change of ownership, change in the name of the business, or change in the Tax Identification Number (TIN). Failure to notify Medicare of changes may result in revocation of provider billing privileges, thereby preventing payments from Medicare.

Additional Provider Enrollment Information
Additional information regarding application for provider numbers, adding/deleting group members, or changes to addresses is available at http://www.cms.hhs.gov/MedicareProviderSupEnroll/03_EnrollmentApplications.asp

SUSPENSION OF PROVIDER PAYMENTS

CMS has the authority to suspend payment to a provider if fraud is suspected or if an overpayment exists. This action may be necessary to protect the Medicare Program against financial loss. Payment suspensions may last up to 180 days and, in certain cases, an additional 180-day payment suspension may be imposed, or the payment suspension may be imposed for an indefinite period.

Claims submitted by a provider during a payment suspension will continue to be processed, and the provider will continue to be notified of claim determinations. In addition, appeal rights are available for the processed claims. However, Medicare withholds the actual payment(s) for the claims. The withheld payment(s) may be used to offset or recoup overpaid funds identified by Medicare.

There are no appeal rights to the decision to suspend payments. However, providers may submit written rebuttals addressing why a payment suspension should not be imposed. A payment suspension may be lifted once the overpaid funds are recovered or if sufficient information is in the provider's rebuttal statement to demonstrate that the payment suspension is not necessary.

CIVIL MONETARY PENALTIES

Section 1128A(a) of the Social Security Act authorizes the imposition of Civil Monetary Penalties (CMPs) when it is determined that a person or entity has violated Medicare rules and regulations. The following are some examples of violations for which CMPs and additional assessments may be imposed (and in some instances exclusion from the program may apply):

- Violation of the Medicare assignment provisions;
- Violation of the Medicare physician or supplier agreement;
- False or misleading information expected to influence a discharge decision;
- Violation of assignment requirement for certain diagnostic clinical laboratory tests;
- Violation of requirement of assignment for nurse-anesthetist services;
- Supplier refusal to supply rental DME supplies without charge after rental payments may no longer be made;
- Physician billing for assistants at cataract surgery without prior approval of the Quality Improvement Organization (QIO);
- Hospital unbundling of outpatient surgery costs; or
- Hospital/responsible physician “dumping” of patients based upon their inability to pay or lack of resources.

Typically, penalties involve assessments of significant damages such as CMPs up to $10,000 per violation and exclusion from the Medicare Program for a minimum of five years.

INVESTIGATIONS

In cases of substantiated allegations of fraud or suspected inappropriate activities, Medicare contractors and/or Federal law enforcement may investigate individuals and providers or suppliers for subsequent prosecution.

CRIMINAL PROSECUTIONS AND PENALTIES

Because it is a Federal crime to defraud the Federal Government or any of its programs, individuals who commit fraud may be imprisoned, fined, or both. Criminal convictions usually include restitution and significant fines. In some states, providers and healthcare organizations may also lose their licenses. Convictions may also result in exclusion from Medicare participation for a specific length of time.

CIVIL PROSECUTIONS AND PENALTIES

The U.S. Attorney's Office may file a civil suit or decide that the interest of the Medicare Program is best served by settling a case. In these situations, the amount of damages plus additional money may be paid to the Federal Government in the form of penalties and fines. Depending on the severity of the case, the civil suit or settlement may include the following:

- CMP to the Federal Government for no more than $10,000 for each item or service in non-compliance (or higher amounts where applicable by statute);
- Penalty assessment payment to the Federal Government for up to three times the amount claimed for each item or service in lieu of damages sustained by the Federal Government;
- Exclusion from Medicare or any other Federally funded program for a specified number of years; or
- Imposition of a “Corporate Integrity Agreement” with the Federal Government. In these instances, the individual or entity is required to accomplish specific goals (e.g., educational plan, corrective action plan, reorganization) and is also subject to periodic audits by the Federal Government.

EXCLUSION AUTHORITY

The OIG has the authority to exclude (sanction) providers or suppliers who have been convicted of health care-related offenses. Even when the U.S. Attorney's Office declines to prosecute a case, the OIG may act to exclude the providers from the Medicare Program. The term exclusion means that, for a designated period, Medicare, Medicaid, and other Government programs will not pay the provider for services performed or for services ordered by the excluded party.

In addition, under Section 1128A(a) of the Social Security Act, many of the penalties imposed under this section may also cause exclusion from the Medicare Program. The authority to exclude providers and suppliers under this statute is delegated to CMS or the OIG, depending on which agency was delegated authority for the specific violation from the Secretary of the SSA.

Refer to Section 1128, 42 U.S.C. 1320a-7 of the Social Security Act for the mandatory and permissive exclusions discussed in the following sections.

Mandatory Exclusions

A mandatory exclusion exists if there is a conviction of fraud. Examples of mandatory exclusions can be found in the Social Security Act.

Permissive Exclusions

A permissive exclusion exists when there is no conviction of fraud; however, certain conditions and requirements have been met. Examples of permissive exclusions can be found within the Social Security Act.

Exclusion Information
A complete list of exclusions and other information related to exclusions is available at http://www.oig.hhs.gov/fraud/exclusions.html on the Web.

PAYMENT DENIALS DUE TO EXCLUSION

Medicare will not pay an excluded individual, or an entity that has accepted assignment. Medicare will also not pay a beneficiary who submits claims for items and services furnished on or after the effective date of a sanction. In addition, Medicare will not pay for services/items furnished on the order or referral of an excluded individual or entity.

DENIAL OF PAYMENT TO A SUPPLIER

Medicare will not pay for any items or service that an excluded party furnishes, orders, or prescribes. This payment prohibition applies to the excluded person and anyone who employs or contracts with the excluded person. The provider is ultimately responsible for establishing that the items and services billed were not furnished, ordered, or prescribed by an excluded individual.

DENIAL OF PAYMENT TO A PROVIDER OF SERVICE (POS)

A POS that is wholly owned by an excluded party will not be paid by Medicare for services performed or items received (including services performed under contract) by an excluded party on or after the effective date of the sanction.

DENIAL OF PAYMENT TO BENEFICIARIES

If a beneficiary submits claims for items or services furnished by an excluded party or by a supplier that is wholly owned by an excluded party on or after the effective date of the sanction:

- Medicare may pay for the first claim submitted by the beneficiary, and will immediately give the beneficiary notice of the sanction.
- Medicare will not pay the beneficiary for items or services furnished more than 15 days after the date of the notice to the beneficiary.

EXCEPTIONS TO PAYMENT DENIALS

Payment is available for services or items provided up to 30 days after the effective date of the sanction for:

- Inpatient hospital services or post-hospital Skilled Nursing Facility (SNF) services or items furnished to a beneficiary who was admitted to a hospital or SNF before the effective date of the sanction; or
- Home health services or items furnished under a plan of treatment established before the effective date of the sanction.

The Medicare and Medicaid Patient and Program Protection Act of 1987 (P.L. 100-93) permits payment for an emergency item or service furnished by an excluded individual or entity.

REINSTATEMENT

At the conclusion of the designated period of sanction, an individual and/or entity may be eligible for reinstatement to the Medicare Program and may apply to OIG for reinstatement.

OIG LIST OF EXCLUDED INDIVIDUALS/ENTITIES (LEIE)

The OIG's sanctioned LEIE identifies individuals and entities that are excluded from Medicare reimbursement. In addition, the list includes the provider's specialty, notice date, and the end of the sanction period. The OIG LEIE also identifies individuals and entities that have been reinstated to the Medicare Program.

Accessing the LEIE
The OIG-sanctioned LEIE is available at http://www.oig.hhs.gov/ on the Web. Once at this address, click on “Exclusions Database”.

GOVERNMENT SERVICES ADMINISTRATION (GSA) EXCLUDED PARTIES LISTS SYSTEM (EPLS)

The GSA was established by the Federal Property and Administrative Services Act. Its role is to examine ways to improve the administrative services of the Federal Government. The GSA website contains debarment actions taken by various Federal agencies, in addition to those of the OIG LEIE exclusions database.

GSA EPLS Lists
The GSA debarment, exclusion, and suspension lists for all Federal Agencies are available at http://epls.arnet.gov on the Web.

The EPLS website assists Medicare and Medicaid contractors in verifying the eligibility of healthcare providers or suppliers and/or entities seeking to participate in the Medicare and Medicaid programs. CMS encourages individuals and entities to research the information on this website before adding a provider or supplier to a physician group or medical staff, purchasing or considering involvement in a medical facility or other entity that may seek payment from Medicare.

NOTES

Proper payment of Medicare claims is a result of the joint efforts of the physician, other clinicians, the supplier, and billing personnel. This goal requires meeting the Medicare payment contractor's payment policy requirements that combine national and local policy. This section introduces common claim errors that result in claim rejections or claim denials and describes the general requirements for properly resubmitting rejected claims or appealing a denied claim.

If a claim is not paid as submitted, there are three general types of deficiencies identified by the Medicare payment contractor:

- Billing/data entry errors;
- Noncompliance with coverage policy; and
- Billing for services that are not medically necessary.

In many cases, the claim either could not be paid as initially submitted, or was denied because the payment contractor required additional documentation or a correction to the claim data.

WHAT CONSTITUTES A BILLING/DATA ENTRY ERROR?

Billing or data entry errors are generally described as errors and/or omissions contained within the Form CMS-1500 claim form itself (or the electronic claim equivalent). Omissions generally indicate that required fields were left blank [e.g., no International Classification of Disease - Ninth Edition, Clinical Modification (ICD-9-CM) diagnosis code entered in Item 21 of Form CMS-1500]. Errors could occur in situations where improper code numbers are entered, such as a nonexistent or retired Health Care Common Procedure Coding System (HCPCS) code.

Acceptable Electronic Claim Formats
Electronic claims must be in National Standard Format (NSF) or American National Standards Institute (ANSI) format. After HIPAA requirements become effective for a provider, electronic claims MUST be in ANSI X12N format. For a crosswalk of paper claim items to the corresponding NSF and ANSI electronic claim fields, refer to the *Medicare Claims Processing Manual*, Chapter 26, Completing and Processing Form CMS-1500 Data Set, available at http://www.cms.hhs.gov/manuals IOM/list.asp on the Web. This crosswalk is also included within Reference C.

Errors could also occur when the procedure and diagnosis codes on the claim form do not match the clinical documentation (transposition errors). Most claim documentation errors are identified by the payment contractor's automated systems; however, incorrect entry of the following billing/data entry information pertaining to Part B physicians and suppliers often results in claim rejections and can also result in claim denials:

- Beneficiary name/Health Insurance Claim Number (HICN)/Sex;

- Billing provider;
- Diagnosis;
- Late filing;
- Modifiers;
- Performing provider number;
- Place of Service (POS) code;
- Procedure code;
- Quantity billed; and
- Unique Provider Identification Number (UPIN).

Each data entry error is described in the following tables and suggestions are provided for resolving the issue. Table 5-1 contains common billing errors affecting Part B physicians and suppliers.

HOW ARE COVERAGE POLICY COMPLIANCE ISSUES IDENTIFIED?

Payment contractors may identify errors in coverage policy compliance by utilizing automated systems that use logic programming to match code combinations (e.g., ICD-9-CM codes with HCPCS codes), or through manual Medical Review (MR). Coverage policy denials are supported in statute under Section 1862 of Title XVIII of the Social Security Act.

Table 5-1. Common Billing Errors Affecting Part B Physicians and Suppliers.

Beneficiary Name/Health Insurance Claim Number (HICN)/Sex Error:
The Medicare beneficiary name, (HICN), and sex are required information. This information is often incorrect for the following reasons: ❖ The Medicare beneficiary's name is misspelled or does not match the eligibility file; ❖ The Medicare beneficiary's HICN is incorrect, incomplete, or missing; or ❖ The Medicare beneficiary's sex is incorrect or missing.
Resolution:
1. Verify the Medicare beneficiary's name, HICN, and sex against the red, white, and blue Medicare health insurance card. 2. Enter the Medicare beneficiary's first and last name in Item 2 of Form CMS-1500 or the electronic claim equivalent (see Reference C). The name must be alphabetic. 3. Enter the HICN in Item 1a of the Form CMS-1500 or the electronic claim equivalent (see Reference C). The nine characters must be numeric. The 10th character must be alphabetic (no space). The 11th and 12th characters must be alpha-numeric (no spaces). 4. Enter the beneficiary's sex in Item 3 of Form CMS-1500 or the electronic claim equivalent (see Reference C). Valid values: Female (F) or Male (M).
Billing Provider Error:
The payment contractor-assigned group number/Provider Identification Number (PIN) of the billing provider is required. The group number/PIN is often incorrect or missing.
Resolution:
1. Verify the group number/PIN. 2. Enter the group number/PIN in Item 33 of Form CMS-1500 or the electronic claim equivalent (see Reference C).
Diagnosis Error:
ICD-9-CM diagnosis codes are required information. This information is often considered incorrect because the ICD-9-CM diagnosis code is missing or invalid.

Resolution:

1. Verify the ICD-9-CM diagnosis code.
2. Enter the ICD-9-CM diagnosis code, to the highest level of specificity (coding to the fourth or fifth digit), in Item 21 of Form CMS-1500. The principal diagnosis code is listed first and up to three additional claim ICD-9-CM code numbers may also be entered, or the electronic claim equivalent (see Reference C).

Late Filing Error:

Medicare claims must be filed within certain time limits or the service(s) will be denied.

Resolution:

Medicare law requires that a claim for services be filed no later than the end of the calendar year (CY) following the year in which the service was furnished, with the exception of services furnished in the last three months of the year. Services furnished within the last three months of a year must be filed by December 31st of the year following the year in which the services were furnished.
Example: October 1, 2002, through September 30, 2003, must be filed by December 31, 2004.

Modifier Errors:

Modifiers are two-digit codes that are entered on the claim form to modify payment of a procedure or to assist the Medicare payment contractor in determining appropriate coverage or otherwise identify the detail being billed. This information is often incorrect for the following reasons:

- An inappropriate modifier is used;
- An invalid modifier is used; or
- An appropriate modifier is missing.

Resolution:

1. Verify what modifier should be used, if any.
2. Enter the appropriate modifier in Item 24D of Form CMS-1500 or the electronic claim equivalent (see Reference C).

Note: Certain modifiers should **NOT** be submitted on Medicare Part B claims since they will be added during claims processing, if appropriate. These modifiers include 51, CC, XU, XW, XY, XZ, and XQ.

Procedure Code Error:

The services rendered are identified by HCPCS codes. This information is often incorrect because the HCPCS code(s) is missing or invalid.

Resolution:

1. Verify the HCPCS code(s).
2. Enter the HCPCS code(s) in Item 24D of Form CMS-1500 or the electronic claim equivalent (see Reference C).

Quantity Billed Error:

This value is the unit of services. The services must be equal to or greater than “1”. The services cannot be greater than “99”. The fourth position is an implied decimal. One unit equals “0010”. This information is often incorrect for the following reasons:

- The quantity billed is missing;
- The quantity billed does not correspond with the multiple visit dates entered;
- For anesthesia, the elapsed time (hours) has not been converted into minutes and the total minutes given for a procedure; or
- The provider billed multiple units for procedure codes that are not time-based.

Resolution:

1. Verify the quantity billed.
2. Enter the quantity billed in Item 24G of Form CMS-1500 or the electronic claim equivalent (see Reference C).

Performing Provider Number Error:

The carrier-assigned Provider Identification Number (PIN) of the performing provider is required for services rendered by a physician/supplier within a group practice. When several different providers of service or suppliers within a group are billing on the same Form CMS-1500, the individual PIN must be identified. This information is often incorrect for the following reasons:

- The performing provider PIN was missing;
- The performing provider PIN was entered incorrectly; or
- The performing provider PIN entered does not match the group practice number provided.

Resolution:

1. Verify the performing provider PIN.
2. Enter the performing provider PIN in Item 24K of Form CMS-1500 or the electronic claim equivalent (see Reference C).
3. When several different providers of service within a group practice are billing on the same claim, enter the individual PIN for each performing provider as it corresponds with the service rendered.

Place of Service (POS) Error:

This code identifies the location for each item used or service performed.

This information is often incorrect because the POS code is missing or invalid.

Resolution:

1. Verify the POS code.
2. Enter the appropriate POS code in Item 24B of Form CMS-1500 or the electronic claim equivalent (see Reference C).

Unique Physician Identification Number (UPIN) Error:

The (UPIN) and physician name is required information when a claim involves referring and/or ordering physician services. This information is often incorrect for the following reasons:

- The UPIN and provider name was missing; or
- The UPIN and physician name used is invalid for the services referred (e.g., chiropractic services, self-referred consultations).

Resolution:

1. Verify the referring provider's UPIN at the time of referral.
2. Enter the referring/ordering physician's name and UPIN in Items 17 and 17a of Form CMS-1500 or the electronic claim equivalent (see Reference C).
3. Ensure the UPIN and physician name are valid for referral of the type of service rendered.

SSA Coverage Policy Denial Information
Additional information regarding SSA coverage policy denials is available at http://www.ssa.gov/OP_Home/ssact/title18/1862.htm on the Web.

A provider must be aware of the following layers of coverage policy under Medicare:

- Statutorily excluded services;
- Regulations;
- National Coverage Determinations (NCDs);
- Coverage provisions in interpretive manuals; and
- Local Medical Review Policies (LMRPs) and Local Coverage Determinations (LCDs).

TOP COMPLIANCE ISSUES RESULTING IN CLAIM DENIALS OR CLAIM REJECTIONS

Patient coverage may be denied or the claim rejected for the following reasons:

- The patient is not entitled to Medicare services;
- The provider is not qualified to furnish the Medicare services billed;
- Medicare is the secondary payer to other insurance;
- Services are excluded by statute, national, or local coverage policy;
  - There is no benefit for the service;
  - The limited benefit is exhausted; or
- Claim/Services do not meet technical requirements for payment (including national and local requirements). These include, but are not limited to:
  - Certification;
  - Plan of care;
  - Certificate of Medical Necessity (CMN) for Durable Medical Equipment (DME); and
  - Compliance with Correct Coding Initiative (CCI) edits.

WHEN THE PATIENT IS NOT ENTITLED TO MEDICARE SERVICES

A provider or supplier should determine a patient's eligibility before providing services to help prevent a claim denial or claim rejection because the patient is not entitled to Medicare services. The provider or supplier can determine eligibility by obtaining a copy of the beneficiary's red, white, and blue Medicare card during his or her first visit and confirming eligibility for the services to be furnished and billed.

What is NOT Covered by Medicare

The following general medical services are not covered under Medicare Part A or B:

- Acupuncture;
- Ambulance transportation to a doctor's office;
- Blood transfusions after the first three pints of blood;
- Cosmetic surgery unless it is needed to improve function of a malformed part of the body that was accidentally injured;
- Custodial care at a nursing home whenever this is the only kind of care required by the patient;
- Routine dental care or most dental procedures such as cleanings, fillings, tooth extractions, dentures, dental plates, or other dental devices;
- Emergency inpatient services in foreign countries except for some instances in Canada and Mexico to include:
  - When the patient is traveling within the U.S., a medical emergency occurs, and the closest hospital that can provide adequate treatment is in either Canada or Mexico;
  - When the patient is traveling through Canada without unreasonable delay by the most direct route between Alaska and another state and a medical emergency occurs and the Canadian hospital is closer than the nearest U.S. hospital that can treat the emergency; or

- The patient lives in the U.S. and the Canadian or Mexican hospital is closer to the patient's home than the nearest U.S. hospital that can treat the medical condition, regardless of whether an emergency exists.
- Routine eye exams;
- Routine foot care;
- Health and wellness education;
- Routine hearing exams;
- Private nursing duty, television, or telephone in a patient's inpatient hospital room;
- A private room in a hospital unless it is deemed medically necessary;
- Custodial care;
- Medical Nutritional Therapy (MNT) services if the patient has diabetes or kidney disease but is on dialysis;
- Transportation to receive routine health care; or
- Workers' Compensation (WC) claims.

The following general items are not covered under Medicare Part B:

- Bathroom supplies such as tub railings;
- Blood pressure monitor (unless the patient is receiving home dialysis);
- White canes for the blind;
- Hearing aids;
- Experimental items during a clinical trial providing and testing new types of medical care;
- Diabetic supplies not ordered by the physician;
- Diabetic supply refills sent automatically by a supplier to the patient;
- Diabetic supplies such as insulin (unless used with an insulin pump), insulin pens, syringes, or needles;
- Adult diapers;
- Common medical supplies such as alcohol swabs, bandages, and gauze;
- Supplies and/or DME provided by a supplier that is not currently enrolled in Medicare and does not have a current Medicare supplier number, even if the supplier is a large chain or department store that sells more than just DME;
- DME that is used in a Skilled Nursing Facility (SNF);
- Eyeglasses (except for one pair of standard frames, intraocular lenses, or contact lenses after cataract surgery);
- Portable oxygen when provided as a backup to a stationary oxygen system or used in an SNF;
- Most outpatient prescription drugs **except for** some antigens, osteoporosis drugs (covered while receiving home health care), Epoetin alfa (Epogen®), hemophilia clotting factors, immunosuppressive drugs, oral cancer drugs (if available in injectable form), and oral anti-nausea drugs;
- Orthopedic shoes and shoe inserts unless they are a necessary part of a leg brace and the cost is included in the charge for the brace;
- Outpatient substance abuse treatment if the treatment center does not participate in Medicare;
- Surgical stockings;
- Wheelchairs if the patient is able to walk, but has difficulty walking long distances;
- Wheelchair ramps, elevators, stair glides, or some other lift devices; or
  Note: Some lift chairs and chair lift mechanisms are covered.
- Wigs.

WHEN THE PROVIDER IS NOT QUALIFIED TO FURNISH THE MEDICARE SERVICES BILLED

A provider billing office must be aware of the status of not only their billing provider number, but whether all physicians and clinicians furnishing and billing for Medicare covered services through the provider PIN are legally able to participate in the Medicare Program. It is the provider's responsibility to assure that he or she does not bill Medicare for services furnished by "excluded" individuals. For additional information regarding how providers can identify "excluded" individuals so that if they are employed within the provider's office they will not provide any Medicare services, refer to Part 4, Payment Denials Due to Exclusion.

MEDICAL NECESSITY ISSUES

Errors in compliance with medical necessity policy may be identified by payment contractors either by automated systems that use logic programming to match code combinations (e.g., ICD-9-CM codes with HCPCS codes) or through manual MR. Medical necessity denials are all supported in statute under Section 1862(a)(1)(A) of Title XVIII of the SSA. Denials based upon medical necessity determinations can always be appealed.

Payment contractors [carriers and fiscal intermediaries (FIs)] and program safeguard contractors (PSCs) are responsible for determining medical necessity. A description of local coding and documentation requirements that are used to determine that that services furnished and billed for were medically necessary is located in the Local Medical Review Policies (LMRPs).

SSA Medical Necessity Denial Information
Additional information regarding medical necessity denials supported by the SSA is available at http://www.ssa.gov/OP_Home/ssact/title18/1862.htm on the Web.

Medicare Coverage Database Containing LMRPs and LCDs
The LMRPs and LCDs are available in the Medicare Coverage Database at http://www.cms.hhs.gov/mcd/search.asp

If a provider's or supplier's claim is denied based on medical necessity, the applicable LMRP or LCD should be reviewed for additional information.

The following section highlights the most common reasons for medical necessity denials and provides suggestions for resolving the issues and preventing future denials for medical necessity reasons.

TOP COMPLIANCE WITH MEDICAL NECESSITY ISSUES - RESULTING IN CLAIM DENIALS OR CLAIM REJECTIONS

The following compliance issues could result in a Part B claim denial or claim rejection:

- The HCPCS code is not medically necessary to treat the ICD-9-CM diagnosis code;
- HCPCS code is billed at a frequency that is considered not medically necessary;
- The treatment furnished is considered to be beyond acceptable attainment of goals or is for maintenance purposes; or
- Insufficient documentation.

WHAT DEFINES A CLAIM THAT CANNOT BE PROCESSED?

A claim that cannot be processed was submitted but was missing information that is required for processing. Any paper claims that cannot be processed are returned to the physician or supplier through the Remittance Notice. The Remittance Notice will contain messages that describe what required information is missing, thus making it unable to be processed. To correct a paper claim that cannot be processed, the physician or supplier's office must submit a corrected claim for processing.

HOW ARE CLAIMS RETURNED?

When Form CMS-1500 is returned with a cover letter explaining what information is missing, a corrected claim must be re-filed by the physician or supplier. These claims cannot be entered into the system for processing until the requested information is included and resubmitted on Form CMS-1500. If the physician or supplier needs additional information or assistance with providing the appropriate information, call the contractor's customer service line.

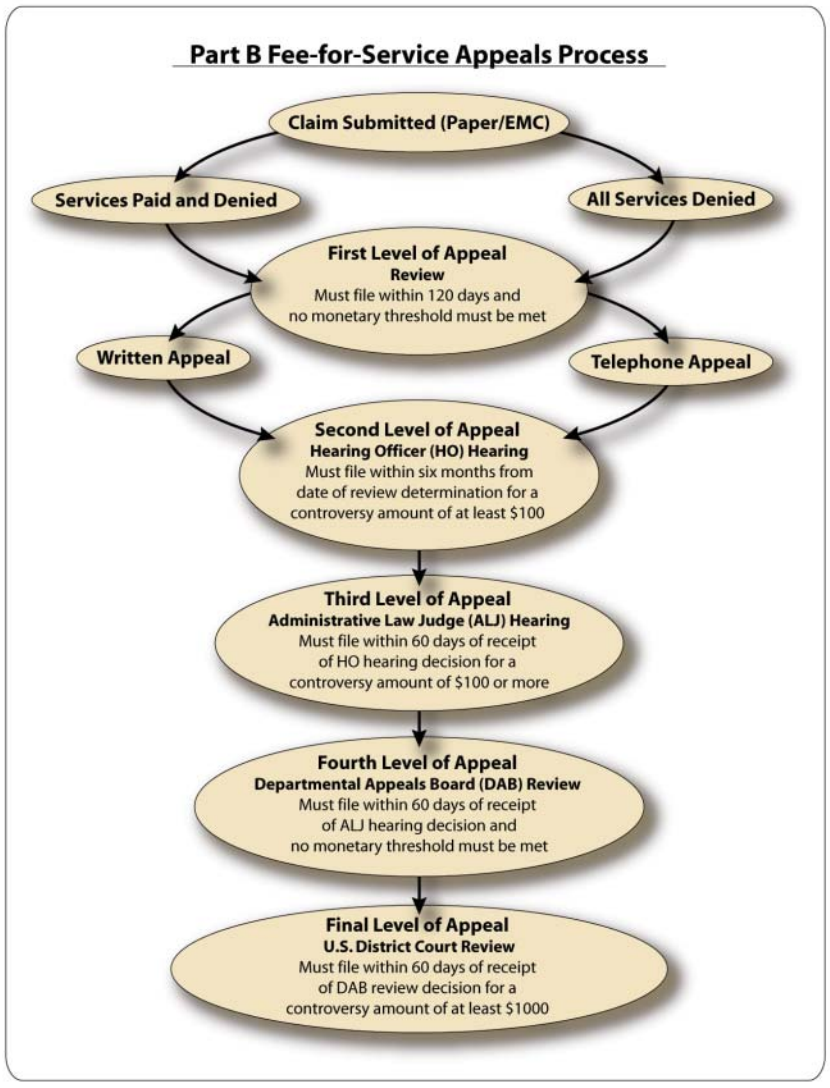
HOW CAN PART B CLAIM DENIALS BE APPEALED?

The current Part B fee-for-service appeals process is depicted in Figure 5-1. Please note that this appeals process is being updated as a result of recent changes in Medicare law. Before initiating an appeal, providers should confirm the current process (including time limits and monetary thresholds with their carriers).

FIRST LEVEL OF APPEAL - REVIEW

After the initial determination has been made on a Part B claim, the first level of appeal is a review. A review is a second look at the claim and supporting documentation by a different employee. A review request can be made either in writing or by telephone.

Figure 5-1. Part B Fee-for-Service Appeals Process.



Current Appeals Policy Information
Current appeals policy can also be located in Chapter 29, Section 60, of the *Medicare Claims Processing Manual*, available at http://www.cms.hhs.gov/manuals/IOM.list.asp on the CMS website.

WRITTEN REVIEW REQUEST

The purpose of a written review request is to contest the initial determination made on a Part B claim. A written review request must be filed within 120 days of the date of the initial determination for claims that were processed after September 30, 2002. No monetary threshold is required to be met. Section 1842(b)(2)(B)(i) of the Social Security Act requires that 95% of all review requests be completed within 45 days of the date the request is received.

The following information must be included within a written review request:

- The beneficiary name and HICN;
- The physician or supplier's name and address;
- The date of initial determination;
- The date of service for which the initial determination was issued; and
- The signature of the appellant.

If any of the above-listed information is missing from the written review request, the review request will be returned to the physician or supplier with an explanation of what must be included. Since most of this information is found within Form

Where to Obtain a CMS 1964 Request for Review Form
A CMS 1964 Request for Review form can be ordered from the contractor or downloaded at http://www.hhs.gov/dab/dabformfinal/pdf on the CMS website.

CMS-1500 and the Medicare Remittance Notice (MRN), the relevant information may be highlighted on the forms and they may be filed together with a signed review request and an explanation for the request.

Helpful Hints for Filing a Written Review Request

It is very helpful and sometimes necessary to submit an indication of why the service should be paid. It is especially helpful to include any documentation that would be needed to conduct the review. Supporting documentation may include, but is not limited to:

- Operative notes;
- Progress notes;
- Office notes; or
- A letter from the physician.

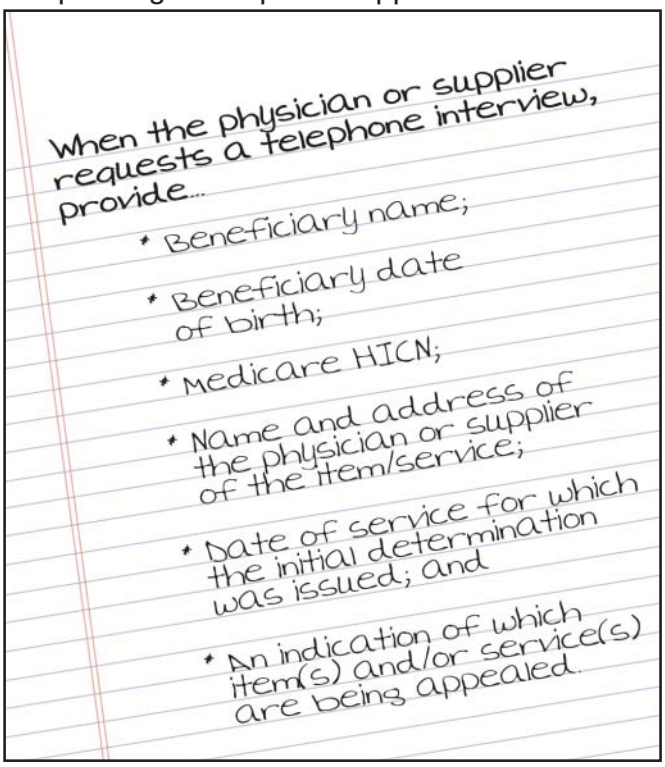
If documentation that is needed to make a review determination is not included with the request, it may be requested from the physician or supplier. The physician or supplier will be given 14 days to provide the requested documentation.

When a party requests a review of an assigned claim, the physician or supplier, and the patient, will be notified of the review determination because both are parties to the appeal. This notification will be in the form of a letter, a revised Medicare Summary Notice (MSN), or an MRN. If all services in question are paid, then the parties will receive a revised MSN or MRN; however, if any service in question is partially or fully denied, the review determination will come in the form of a letter. The physician or supplier can make a review request for a non-assigned claim if the beneficiary completes and signs the Appointment of Representation Form (Form CMS-1696), or if he or she is required to provide a refund to the beneficiary pursuant to Section 1842(l) of the Social Security Act.

TELEPHONE APPEALS

Review requests are accepted over the telephone at some contractors; however, the type and complexity of the issues involved in the review will determine if the request will be completed as a telephone review or transferred to the written review department for completion. See Figure 5-2 for a checklist of information a requestor must provide when requesting a telephone appeal.

Figure 5-2. Information Checklist for Requesting a Telephone Appeal.



The following list provides examples of the reviews that can be conducted by phone:

- Number of services/units;
- The addition, changing, or deletion of certain modifiers;
- ICD-9-CM diagnosis codes;
- Erroneous denials (duplicates);
- Procedure codes;
- POS codes; and
- Dates of service.

Note: Proof to support a verbal review request made on behalf of a beneficiary must be submitted via fax. Any requested supporting documentation must be faxed within 48 hours of the request for the phone review, and within 14 days for reviews that are transferred to the written appeals area. When documentation is faxed, it must reference the confirmation/control number assigned to the appeal. If the requested documentation is not received with the stated timeframes, the appeal decision will be based on the information in the file.

The following types of reviews are always inappropriate for a telephone appeal:

- Claims requiring input from the medical staff or entities outside the Appeals Unit [e.g., Operative Report, CMS, Common Working File (CWF) System, provider enrollment]; and
- Claims submitted with the incorrect billing provider name or number (Item 33 on Form CMS-1500).

SECOND LEVEL OF APPEAL - HEARING OFFICER (HO) HEARINGS

An HO hearing is the second level of appeal for participating physicians, suppliers, and beneficiaries who are dissatisfied with their review determination. Section 1842(b)(2)(B)(ii) of the Social Security Act requires contractors to make a final determination for 90% of all HO hearings within 120 days of receipt of the hearing request.

The following requirements must be met to receive an HO hearing:

- A request for hearing must be in writing and signed by the requestor;
- The request must be filed with CMS, the contractor, or an office of the Social Security Administration (SSA) or Railroad Retirement Board (RRB) within six months of the receipt date of the review determination; and
- The amount in controversy must be at least $100.

A letter acknowledging receipt of the hearing request will be sent within 21 days of receipt of the request. If the request was not made in a timely manner or does not meet the amount in controversy requirement, it will be dismissed and a letter will be sent explaining the reason for the dismissal.

The following three types of HO hearings are available to the requestor:

- **In-Person Hearing** - The requestor or his or her representative has an opportunity to appear in-person in front of an HO and present information supporting the claim and challenging the information the contractor used to reach the previous determination. The hearing will be held at a location that is reasonably convenient for the appellant and the HO.
- **Telephone Hearing** - A telephone hearing differs from an in-person hearing in that the hearing is conducted entirely over the telephone, rather than in person. The appellant and/or his or her representative, may also submit additional written evidence by mail or facsimile.
- **On-The-Record (OTR) Hearing** - If the requestor chooses not to appear in person or have a hearing by telephone, he or she may choose an OTR hearing. In an OTR hearing, the requestor will not present oral testimony. The major advantage of an OTR hearing is that a decision will be quickly rendered to the requestor based on the facts in the file and any additional information that was submitted to the HO. If documentation is not included in the request that is needed to make a determination, the information may be requested from the physician or supplier.

If the requestor specified the type of hearing preferred, no further action is required on his or

her part unless the HO assigned to the case contacts him or her.

If the type of hearing is not specified by the requestor, the acknowledgment letter will provide him or her with an available choice of hearings. The requestor must choose a hearing type and return the letter as soon as possible. Alternatively, the HO may contact the requestor by telephone to determine the type of hearing that he or she wishes to have.

THIRD LEVEL OF APPEAL - ADMINISTRATIVE LAW JUDGE (ALJ) HEARING

If a party to the HO hearing is dissatisfied with the decision and the amount in controversy is $100 or more, the party can request a hearing before an ALJ. The request must be submitted within 60 days of his or her receipt of the HO's decision. This function is currently performed by ALJs employed by the SSA's Office of Hearing and Appeals (OHA). The ALJ hearing results in a new decision by an independent adjudicator.

HOW TO REQUEST A PART B ALJ HEARING

To request an ALJ hearing, the requestor must file a written request for a Part B ALJ hearing with the Medicare contractor, CMS, or at an office of the SSA or RRB, within 60 days of the date of his or her receipt of the HO's decision. If a request is sent directly to the carrier or FI, the request will be forwarded with the case file to the SSA/OHA Division of Medicare - Part B. Once an ALJ hearing has been requested, the ALJ obtains jurisdiction over the case.

FOURTH LEVEL OF APPEAL - DEPARTMENTAL APPEALS BOARD (DAB) REVIEW

After a decision has been made by at an ALJ hearing on a Part B claim, the next level of appeal is a DAB review. A request for DAB review must be made within 60 days of receipt of the ALJ's decision. No monetary threshold is required to be met. The request may be submitted by letter or by using the Request for Review Form (DAB-520). See Figure 5-3 for a checklist of information a requester must provide when requesting a DAB Review.

If a requestor is dissatisfied with the DAB's decision, he or she must then commence civil action and request a Federal District Court hearing within 60 days of receipt of the DAB's decision. The requestor must file the complaint with the U.S. District Court, not the carrier. The U.S. District Court may remand the case to the DAB or ALJ for further proceedings.

How to Contact the ALJ
After the ALJ assumes jurisdiction over a case, all inquiries should be submitted to the following address:

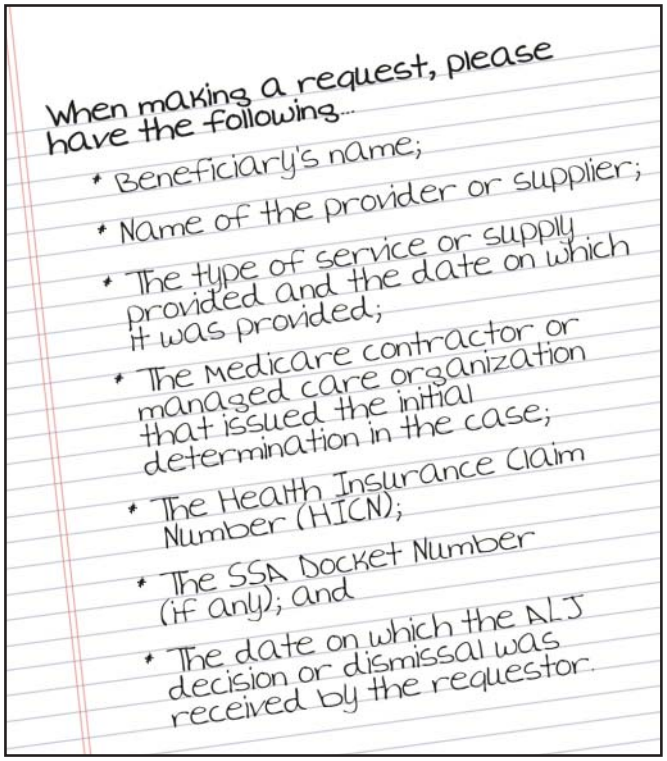
SSA/Office of Hearings and Appeals
Division of Medicare - Part B
5107 Leesburg Pike, Suite 502
Falls Church, VA 22041-3255

Phone inquiries pertaining to the status of a request for a Part B ALJ hearing should be made to the Division of Medicare - Part B at 703-605-8550.

Where to Submit a DAB Request for Review
A request for DAB review should be submitted to the following address:

Department of Health and Human Services
Office of the Secretary
Department of Appeals Board, MS6127
Medicare Appeals Council
Cohen Building, Room G-644
300 Independence Avenue, S.W.
Washington, D.C. 20201

Figure 5-3. Information Checklist for Requesting a DAB Review.



FINAL LEVEL OF APPEAL - FEDERAL DISTRICT COURT REVIEW

If a requestor is dissatisfied with the DAB's decision, he or she must then commence civil action and request a U.S. District Court hearing within 60 days of receipt of the DAB's decision. At least $1,000 must remain in controversy. The requestor must file the complaint with the U.S. District Court, not the carrier. The U.S. District Court may remand the case to the DAB or ALJ for further proceedings.

HOW ARE NCDS AND LCDS REVIEWED?

On December 8, 2003, CMS implemented a new process that permits certain Medicare beneficiaries to challenge coverage policies that may prevent access to items and services or that have resulted in claim denials. These changes were required by Congress per Section 522 of the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Benefits Improvement and Protection Act (BIPA) of 2000. With this new policy, a beneficiary who qualifies as an "aggrieved party" may challenge an LCD or an NCD (or specific provisions therein). Medicare defines an "aggrieved party" in 42CFR §426.110 as follows:

Aggrieved party means a Medicare beneficiary, or the estate of a Medicare beneficiary, who:

(1) Is entitled to benefits under Part A, enrolled under Part B, or both (including an individual enrolled in fee-for-service Medicare, in a Medicare Advantage Plan, or in another Medicare managed care plan);
(2) Is in need for coverage for a service or item that is denied based upon an applicable LCD (in the relevant jurisdiction) or an NCD, regardless of whether the service or item was received; and
(3) Has obtained documentation of the need by the beneficiary's treating physician.

How to Challenge an LCD or NCD

A beneficiary that qualifies as an aggrieved party may challenge an LCD or an NCD by filing a complaint with the office designated by CMS. Beneficiaries may obtain information regarding how to file a complaint by calling the toll-free 1-800-MEDICARE (1-800-633-4227) line. For TTY services call 1-877-486-2048.

How to Challenge an LCD or NCD if Only a Beneficiary can Submit a Request for Review

Providers may continue to participate in the process of developing, revising, or discontinuing an LCD or NCD under existing policies. Part 4, Benefits to Medicare Providers and Suppliers, addresses the policy development process. Procedures for challenging an NCD are located at http://www.cms.hhs.gov/Rulings/downloads/CMSRo101.pdf. Your carrier can provide information regarding how to challenge.

Beneficiaries that have had claims denied that are based upon an LCD or an NCD will have the following message on their MSN:

15.20 - The following policies [carrier-inserted applicable LMRP ID# and/or NCD #] were used when we made this decision.

Note: LMRPs contain LCD policies and often other information such as procedure coding and payment instructions that are not part of an LCD.

In this process, an aggrieved party may not assign legal rights to request a review of an LCD or an NCD to a third party (including a provider). However, a provider is permitted to assist the beneficiary in developing the initial request for review and in navigating the review process. This involvement of a third-party to offer assistance is not mandatory, and unless a provider is subpoenaed under existing regulations, there will be no monetary expenses reimbursed by Medicare.

CMS does not believe that the provisions of this new process will have a significant effect on providers since Congress developed the BIPA 522 policy review process for beneficiaries. Providers may be requested, however, to supply documentation that an aggrieved party is in need of that pertains to a specific service, and to assist in representing an aggrieved party. In addition, the documentation necessary for the review may be in the form of an order or other existing language from the beneficiary's medical record, and need not be newly-created material. Overall, CMS believes that this rule will result in an insignificant economic impact on healthcare providers or the healthcare industry as a whole.

A favorable decision for the beneficiary may result in a previously denied claim being paid by Medicare. In addition, this process may result in a policy change in an LCD or NCD that will affect other beneficiaries in the future. However, the right to challenge NCDs and LCDs is distinct from the existing appeal rights for the adjudication of claims discussed in Part 5, Final Level of Appeal - Federal District Court Review. Thus, a beneficiary may elect to pursue a claims denial through the claims appeal process, seek review of an LCD or an NCD using this process, or both.

NOTES

Part 6
Introduction to HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was enacted for several reasons, such as to:

- Improve portability and continuity of health insurance coverage;
- Combat waste, fraud, and abuse in health insurance and delivery of health care;
- Promote the use of medical savings accounts;
- Improve access to long-term care services and coverage; and
- Simplify the administration of health insurance.

The Centers for Medicare & Medicaid Services (CMS) is responsible for implementing and enforcing various unrelated provisions within HIPAA, therefore HIPAA may have different meanings depending on the circumstances. The two HIPAA provisions that are addressed within this document because they pertain specifically to CMS are HIPAA Insurance Reform (Title I) and HIPAA Administrative Simplification (Title II).

WHAT ROLE DOES CMS HAVE WITH HIPAA?

CMS is responsible for implementing and enforcing the following unrelated provisions of HIPAA:

- **HIPAA Insurance Reform** - Title I of HIPAA protects health insurance coverage for workers and their families when they change or lose their jobs.
- **HIPAA Administrative Simplification** - Title II of HIPAA requires the Secretary of the Department of Health and Human Services (DHHS) to establish national standards for electronic healthcare transactions and national identifiers for providers, suppliers, health plans, and employers. It also addresses the security and privacy of health data. Adopting these standards will improve the efficiency and effectiveness of the nation's healthcare system by encouraging the widespread use of electronic data interchange in health care. Although HIPAA was enacted in 1996, each provision of the

Administration Simplification is set into motion through the issuing of proposed and final regulations. Thus, each part of the Administrative Simplification has different effective dates and different compliance deadlines. CMS is responsible for implementing and enforcing all Administrative Simplification provisions except privacy.

WHAT ARE THE ADMINISTRATIVE SIMPLIFICATION REQUIREMENTS?

The Administrative Simplification Requirements of HIPAA impact healthcare providers and suppliers who do business electronically, as well as many of their healthcare business partners. Many changes involve complex computer system modifications. The Administrative Simplification Requirements of HIPAA consist of four parts (see Table 6-1.)

The Administrative Simplification standards adopted by the Secretary of DHHS under HIPAA apply to any entity that is:

Information Regarding HIPAA Requirements and Coverage

For help with determining whether you are a covered entity, access the decision tool at http://www.cms.hhs.gov/hipaaGenInfo/06_areyou acovered entity.asp on the Web, or access coverage information at http://www.hhs.gov/HIPAAGeninfo/01_overview.asp on the web.

For additional information regarding HIPAA requirements and coverage as a covered entity, contact the HIPAA Hotline at 1-866-282-0659.

Table 6-1. HIPAA Administrative Simplification Requirements.

Electronic Transactions and Code Sets	Security	Unique Identifiers	Privacy
			
HIPAA requires the adoption and use of national standards for certain healthcare electronic transactions and code sets.	HIPAA addresses how electronic health information that is stored, transmitted, and accessed should be secured.	HIPAA requires providers, suppliers, health plans, and employers to adopt and use unique identifiers.	Under HIPAA, covered entities must implement standards to protect and guard against the misuse of individually identifiable health information. The privacy requirements are overseen by the Office of Civil Rights (OCR), an agency within the Department of Health and Human Services (DHHS).

- A healthcare provider or supplier that conducts certain transactions in electronic form or who use a billing service to conduct transactions on his or her behalf.
- All healthcare clearinghouses.
- All health plans.

An entity that is one or more of these types is referred to as a "covered entity" and must comply with the Administrative Simplification requirements of the HIPAA regulations.

ELECTRONIC TRANSACTIONS AND MEDICAL CODE SETS

Under HIPAA, electronic transactions are allowed provided that the transactions meet the requirements established. The requirements include adoption of national standards for electronic transactions, and use of standardized medical code sets used to encode data.

Table 6-2 lists the current electronic standard requirements.

ELECTRONIC TRANSACTIONS

Transactions are activities involving the transfer of healthcare information for specific purposes. Under HIPAA Administration Simplification, if a healthcare provider or supplier engages in one of the identified transactions, he or she must comply with the standard for that transaction. HIPAA requires every provider or supplier who does business electronically to use the same healthcare transaction standards, code sets, and identifiers. HIPAA has identified the following 10 National Standards for Electronic Data Interchange (EDI) for the transmission of healthcare data:

- Premium payments;
- Enrollment in and disenrollment from a health plan;
- Eligibility inquiry and response;
- Referrals and authorizations;
- Claims/encounter data;
- Claim status inquiry and response;
- Payment and Remittance Advice (RA);
- Coordination of Benefits (COB);

Table 6-2. Electronic Standard Requirements.

Electronic Transactions Standards for:	
Claims or Encounters and Coordination of Benefits (COB)	ASC X12N 837 - Professional Healthcare Claims ASC X12N 837 - Institutional Healthcare Claims ASC X12N 837 - Dental Healthcare Claims NCPDP - Telecommunication Version 5.1 and Batch Standard 1.1 - Retail Pharmacy Claims
Healthcare Payment and Remittance Advice (RA)	ASC X12N 835 - Healthcare Payment/Advice
Health Claims Status	ASC X12N 276/277 - Healthcare Claim Status, Request and Response
Eligibility for a Health Plan	ASC X12N 270/271 - Healthcare Eligibility Benefit Inquiry/Response NCPDP - Telecommunication Version 5.1 and Batch Standard 1.1 - Retail Pharmacy Claims
Referral Certification and Authorization	ASC X12N 278 - Healthcare services review - request for review and response NCPDP - Telecommunication Version 5.1 and Batch Standard 1.1 - Retail Pharmacy Claims
Enrollment and Disenrollment in a Health Plan	ASC X12N 834 - Benefit Enrollment and Maintenance
Health Plan Premium Payments	ASC X12N 820 - Payment Order/RA

Transaction Standards, Final Rule Guidelines, Code Set, and Identifier Information
Additional information regarding regulations governing transaction standards, Final Rule implementation guidelines, code sets, and identifier information can be found at http://www.cms.hhs.gov/hipaa/hipaa2/_40.asp regulations on the Web.

HIPPA Implementation Guides
These guides may be downloaded for free at http://www.wpc-edi.com/hipaa/HIPAA_40.asp on the Web.

- First report of injury (pending); and
- Claim attachments (pending).

Standards have been developed for eight of the 10 transactions. Transaction standards have not been developed for claims attachments or for the first report of injury.

Not every covered entity will conduct all of the transactions. For instance, healthcare providers or suppliers would not engage in enrollment into, and disenrollment from, a health plan.

The Standards Development Organizations (SDOs) have developed implementation guides to assist covered entities and their business associates. The implementation guides provide the adopted implementation specifications and comprehensive technical details for HIPAA implementation and include detailed technical specifications that explain how to conduct a standard transaction. These details and specifications include:

- Format specification - how information should be arranged;
- Content specification - what information should be included; and
- Certain code sets - how information will be included using representational codes.

For example, the guides provide important information for an Information Technology (IT) group or vendor that handles electronic data exchange.

Providers and suppliers should also contact their payers and inquire whether they have companion guides available to accompany the implementation guides. If available, companion guides can provide additional information that is helpful in interpreting the implementation guides.

STANDARD MEDICAL CODE SETS

In addition to transaction standards, HIPAA regulations also require the use of standard code sets. Medical code sets include any set of codes used for encoding data elements, such as tables of terms, medical concepts, medical diagnosis, or medical procedure codes. The codes are an integral part of electronic transactions and are used to describe various healthcare services, procedures, tests, supplies, drugs, patient diagnoses; as well as many administrative activities.

E/M Code Information
The most recent E/M codes are contained within Chapter 6 of the *Medicare Resident and New Physician Training Manual*, which is available at http://www.cms.hhs.gov/MLN Products The prescribed use of the E/M codes is contained with Documentation Guidelines (DGs), which will be available at http://www.cms.hhs.gov/MLNGeninfo on the CMS website.

HIPAA refers to code sets as either medical codes (clinical codes) or non-medical codes (non-clinical codes). A subset of the Current Procedure Terminology (CPT)-4 codes includes a set of cognitive Evaluation and Management Service (E/M) codes. These codes are used by all types of physicians to document services performed during patient care. These codes explain how the physician gathered and analyzed information about the patient's illness, determined a condition, and devised the best treatment or course of treatment.

Table 6-2 outlines the code sets that have been adopted under HIPAA.

The transactions and code set regulation adopted these first sets of HIPAA standards. It also created a process to allow anyone to request a change in the standards. Six organizations known as Designated Standards Maintenance Organizations (DSMOs) were designated by the Secretary of DHHS and have agreed to work together to collect requests for changes to HIPAA standards, evaluate the requests, and suggest changes to the standards for the Secretary's consideration.

The six DSMOs include:

- Accredited Standards Committee X12N;
- Health Level Seven, Inc.;
- National Council for Prescription Drug Programs;
- National Uniform Billing Committee;
- National Uniform Claim Committee; and
- American Dental Association (ADA).

DSMO Modification Process
The Secretary may modify a standard, or its implementation guide, no more frequently than once every 12 months. The latest information on the DSMO Modification process can be found at http://www.hipaa-dsmo.org on the CMS website.

Table 6-2. HIPPA-Adopted Medical Code Sets.

HIPPA-Adopted Medical Code Sets for:	
Diagnosis	International Classification of Diseases, 9th revision, Clinical Modification, Vol. 1 & 2 (ICD -9-CM) codes [these volumes are maintained by the Center for Disease Control (CDC)]
Services provided by physicians and other professionals	CPT-4 codes [maintained and copyrighted by the American Medical Association (AMA)]
Products, supplies, and services not included in the CPT-4	HCPCS (Healthcare Common Procedure Coding System) codes [maintained by CMS, Blue Cross Blue Shield (BCBS) associations, and the Health Insurance Association of America]
Dental Terminology	Code used for dental procedures and nomenclature [maintained and copyrighted by the American Dental Association (ADA)]
National Drug Codes (NDCs)	Codes used by retail pharmacies and maintained by the Food and Drug Administration (FDA) within the Department of Health and Human Services (DHHS)]
Remark Codes	Codes used to inform the provider or supplier why a request for payment was fully or partially denied (codes approved by the Accredited Standards Committee X12 and maintained by CMS)
Reason Codes	Codes used to furnish information to supplement a Reason Code or to provide information related to the action. These codes explain why a service was not paid at the amount billed (codes approved by the Accredited Standards Committee X12 and maintained by the ASC X12N Code Maintenance Committee).

Approved Reason and Remark Codes
The master lists of approved Reason and Remark Codes are updated during March, July, and November. The latest master list of Remark Codes is available at http://www.wpc-edi.com/codes/Codes.asp on the Web.

Preparing for Electronic Claims Submission
To help prepare for electronic submission, providers and suppliers who are covered entities can access educational information, Provider Readiness Checklists, and news of upcoming seminars and HIPAA roundtable discussions at http://www.cms.hhs.gov/MLNGenInfo on the CMS website.

HIPAA ELECTRONIC CLAIMS SUBMISSION REQUIREMENTS FOR PROVIDERS AND SUPPLIERS

HIPAA does not require all providers or suppliers who are covered entities to submit claims electronically. HIPAA does require that if a provider or supplier is a covered entity and he or she conducts certain transactions electronically, they must comply with HIPAA standards.

DHHS recognizes that transactions often require the participation of two covered entities, and non-compliance by one covered entity may put the second covered entity in a difficult position. On July 24, 2003, DHHS issued guidance that stated that covered entities that make a good faith effort to comply with HIPAA transactions and code set standards may implement contingencies to maintain operations and cash flow.

On September 23, 2003, Medicare announced that it will implement a contingency plan to accept non-compliant Medicare electronic transactions after the October 16, 2003, compliance deadline. The contingency plan will ensure continued processing of claims from providers who were not able to meet the deadline and would otherwise have had their Medicare claims rejected. The contingency plan permits Medicare to continue to accept and process claims in the electronic formats now in use, giving providers additional time to complete the testing process. Medicare will regularly reassess the readiness of its trading partners to determine how long the contingency plan will remain in effect.

The Administrative Simplification Compliance Act (ASCA) includes a provision that states, **effective October 16, 2003**, Medicare may not pay claims submitted on paper, with certain exceptions. One of the major exceptions is for claims submitted by "a small provider of services or supplier". The term "small provider of services or supplier" is defined to mean:

- A provider of services with less than 25 full-time equivalent employees; and
- A physician, practitioner, facility, or supplier (other than provider of services) with less than 10 full-time equivalent employees.

The term "provider of services" is defined for Medicare by § 1861(u) of the Social Security Act

Claims Submission Information

Electronic Claims
Information regarding compliance with the latest electronic billing requirements is available at http://www.cms.hhs.gov/ElectronicBillingEDITrans/01_overview.pdf on the web.

Paper Claims
Information on the latest CMS regulations regarding the limited acceptance of paper claims in lieu of electronic billing is available at http://www.cms.hhs.gov/ElectronicBillingEDITrans/15_1450.asp on the CMS website.

Contingency Planning
Additional information regarding contingency planning guidelines is available at http://www.cms.hhs.gov/ElectronicBillingEDITrans/17_Contingency.asp on the CMS On the CMS website.

to include seven specific types of institutional or special purpose providers. This term generally describes hospitals, nursing facilities, and other institutional providers that are paid through Medicare fiscal intermediaries (FIs). The terms found in the phrase "physician, practitioner, facility or supplier" are used to describe entities that furnish Medicare services described in § 1861(s) of the Act, and are generally paid through Medicare carriers.

SECURITY STANDARDS

On February 20, 2003, DHHS published the Final Rule for Security Standards for electronic protected health information. The Security Final Rule specifies a series of administrative, technical, and physical security safeguards for covered entities to use to assure the confidentiality, integrity, and availability of protected health information in electronic format. The Security Final Rule adopts standards for the security of electronic protected health information to be implemented by health plans, healthcare clearinghouses, and certain healthcare providers and suppliers. The use of the security standards will improve the Medicare and Medicaid programs, other Federal health programs and private health programs, and the effectiveness and efficiency of the healthcare industry in general by establishing a level of protection for certain healthcare information.

COVERED ENTITY SECURITY REQUIREMENTS

Covered entities are required to maintain reasonable and appropriate administrative, physical, and technical safeguards to ensure the integrity, confidentiality, and availability of healthcare information and to protect against any reasonably anticipated threats or hazards to the security and integrity of the information.

Covered entities must:

- Ensure the confidentiality, integrity, and availability of all electronic protected health information the covered entity creates, receives, maintains, or transmits.
- Protect against any reasonable anticipated threats or hazards to the security or integrity of such information.
- Define safeguards and procedures that protect against any reasonably anticipated uses or disclosures of such information that are not permitted or required.
- Ensure compliance with this final rule by its workforce.

The security compliance dates are April 21, 2005, and April 21, 2006, for small health plans.

The security standards are:

- Scalable: All covered entities must be able to implement these standards. Covered entities are required to assess potential risks and vulnerabilities and to implement reasonable and appropriate security protections. Protections implemented to comply with the standards must be kept current and must be documented.
- Technology neutral: The standards must withstand changes caused by evolving technology without becoming obsolete.

The security standards protect electronic data at rest and in transit. Specific examples of security standards include:

- Administrative Safeguards
  - Security management process
  - Assigned security responsibility
  - Workforce security
  - Information access management
  - Security awareness and training
  - Security incident procedures
  - Contingency plan
  - Evaluation
  - Business associate contracts and other arrangements
- Physical Safeguards
  - Facility access controls
  - Workstation use
  - Workstation security
  - Device and media controls
- Technical Safeguards
  - Access control
  - Audit controls

- Integrity
- Person and entity authentication
- Transmission security

- Policies and Procedures and Documentation Requirements
  - Policies and procedures
  - Documentation

Some of the aforementioned specifications are required and some can be addressed on a case-by-case basis.

Final Rule for Security Standards Information
Additional information on the Security Final Rule can be found http://www.cms.hhs.gov/SecurityStandard/Downloads/securityfinalrule.pdf on the web.

UTILIZING UNIQUE IDENTIFIERS

HIPAA requires the adoption and use, in standard transactions, of the following unique health identifiers:

- The employer identifier;
- The provider identifier; and
- The health plan identifier.

EMPLOYER IDENTIFIER

The final regulations that adopt the employer identifier were published in May 2002. The Rule adopts the Employer Identification Number (EIN), an existing identifier already issued by the Internal Revenue Service (IRS), as the unique identifier for employers for use in standard healthcare transactions. The use of this identifier will improve the Medicare and Medicaid programs, and the effectiveness and efficiency of the healthcare industry in general, by simplifying and enabling the efficient electronic transmission of certain health information.

The compliance date for the employer identifier standard is July 30, 2004, for all covered entities. The compliance date is August 1, 2005, for small health plans.

PROVIDER IDENTIFIER AND HEALTH PLAN IDENTIFIER

The Secretary is expected to adopt the standard unique health identifier for providers in early 2004, and to propose the standard unique identifier for health plans sometime in 2004 as well.

Unique Indentification Information
The latest information on unique identifiers can be found at http://www.cms.hhs.gov/NationalProvidentStand/01_overview.asp on the CMS website.

PRIVACY STANDARDS

The *Standards for Privacy of Individually Identifiable Health Information* (Privacy Final Rule) establishes, for the first time, a set of national standards for the protection of medical records and other health information. DHHS issued the Privacy Final Rule to implement HIPAA. The Privacy Final Rule standards address the use and disclosure of individuals' health information (called "protected health information") by organizations subject to the Privacy Final Rule (called "covered entities"), as well as standards for individuals' privacy rights to understand and control how their health information is used. The DHHS OCR is responsible for implementing and enforcing the HIPAA Privacy Final Rule.

HIPAA Privacy Final Rule
Further guidance on the HIPAA Privacy Final Rule can be found at http://www.cms.hhs.gov/ocr/hipaa/privrulepd.pdf on the CMS website.

A major purpose of the Privacy Final Rule is to define and limit the circumstances in which an individual's protected health information may be used or disclosed by covered entities. A covered

entity may not use or disclose protected health information, except either:

- As the Privacy Final Rule permits or requires; or
- As the subject of the information (or the individual's personal representative) authorizes in writing.

A major goal of the Privacy Final Rule is to assure that individuals' health information is properly protected while allowing the flow of health information needed to provide and promote high quality healthcare and to protect the public's health and well being. The Privacy Final Rule strikes a balance that permits important uses of information, while protecting the privacy of people who seek care and healing. Given that the healthcare marketplace is diverse, the Privacy Final Rule is designed to be flexible, comprehensive, and to cover the variety of uses and disclosures that need to be addressed.

Privacy Final Rule Implementation
Information on CMS implementation of the HIPAA Privacy Final Rule for the Original Medicare Program (fee-for-service Medicare) may be found at http://www.cms.hhs.gov/ocr hipaa/privruled.pdf on the CMS website.
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WHAT INFORMATION IS PROTECTED?

The Privacy Final Rule protects all "individually identifiable health information" held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The Privacy Final Rule calls this information "protected health information (PHI)".

Individually identifiable health information is information, including demographic data, that relates to:

- The individual's past, present, or future physical or mental health or condition;
- The provision of health care to the individual; or
- The past, present, or future payment for the provision of health care to the individual, and that identifies the individual or for which there is a reasonable basis to believe can be used to identify the individual.

Individually identifiable health information includes many common identifiers [e.g., name, address, birth date, Social Security Number (SSN)].

De-Identified Health Information

There are no restrictions on the use or disclosure of de-identified health information. De-identified health information neither identifies nor provides a reasonable basis to identify an individual. There are two ways to de-identify information:

(1) Using a formal determination by a qualified statistician; or
(2) By removing specified identifiers of the individual and of the individual's relatives, household members, and employers. This is required and considered adequate only if the covered entity has no actual knowledge that the remaining information could be used to identify the individual.

NOTICE AND OTHER INDIVIDUAL RIGHTS

Each covered entity, with certain exceptions, must provide a Privacy Practices Notice. The Privacy Final Rule requires that the notice contain certain elements. For example, the notice must describe the ways in which the covered entity may use and disclose protected health information. The notice must also state the covered entity's duties to protect privacy, provide a notice of privacy practices, and abide by the terms of the current notice. The notice must also describe an individual's rights, including the right to complain to DHHS and to the covered entity if he or she believes his or her privacy rights have been violated. The notice must additionally include a point of contact for

further information and for making complaints to the covered entity. Covered entities must act in accordance with their notices.

PRIVACY REQUIREMENTS FOR HEALTHCARE PROVIDERS AND SUPPLIERS

Every healthcare provider and supplier, regardless of size, who electronically transmits health information in connection with certain transactions, is a covered entity. These transactions include claims, benefit eligibility inquiries, referral authorization requests, or other transactions for which DHHS has established standards under the HIPAA Transactions Final Rule. Using electronic technology such as e-mail does not mean a healthcare provider or supplier is a covered entity; the transmission must be in connection with a standard transaction.

The Privacy Final Rule covers a healthcare provider or supplier whether it electronically transmits these transactions directly or uses a billing service or other third party to do so on its behalf. Healthcare providers include all providers of services (e.g., institutional providers such as hospitals) and providers of medical or health services (e.g., non-institutional providers such as physicians, dentists, and other practitioners) as defined by Medicare, and any other person or organization that furnishes, bills, or is paid for health care.

The Privacy Rule excludes, from protected health information, employment records that a covered entity maintains in its capacity as an employer, and education and certain other records subject to, or defined in, the Family Educational Rights and Privacy Act, 20 U.S.C. §1232g.

DISCLOSURE OF PROTECTED HEALTH INFORMATION

A covered entity must disclose protected health information in only two situations:

(1) To individuals (or their personal representatives) specifically when they request access to, or an accounting of disclosures of, their protected health information; and

(2) To DHHS when it is undertaking a compliance investigation or review or enforcement action.

Permitted Uses and Disclosures

A covered entity is permitted, but not required, to use and disclose protected health information without an individual's authorization for the following purposes or situations:

- To the individual (unless required for access or accounting of disclosures);
- Treatment, payment, and healthcare operations;
- Opportunity to agree or object;
- Incident to an otherwise permitted use and disclosure;
- Public interest and benefit activities; and
- Limited data set for the purposes of research, public health, or healthcare operations.

Covered entities may rely on professional ethics and best judgments in deciding which of these permissive uses and disclosures to make.

Authorization Uses and Disclosures

Except as otherwise permitted or required, a covered entity may not disclose protected health information without a valid authorization. A covered entity may not condition treatment, payment, enrollment, or benefits eligibility on an individual granting an authorization, except in limited circumstances.

An authorization must be written in specific terms. It may allow use and disclosure of protected health information by the covered entity seeking the authorization, or by a third party. Examples of disclosures that would require an individual's authorization include disclosures to a life insurer for coverage purposes, disclosures to an employer of the results of a pre-employment physical or laboratory test, or disclosures to a pharmaceutical firm for its own marketing purposes.

All authorizations must be in plain language, and contain specific information regarding the information to be disclosed or used, the person(s) disclosing and receiving the information, expiration, right to revoke in writing, and other data. The Privacy Final Rule contains transition provisions applicable to authorizations and other express legal permissions obtained prior to April 14, 2003.

Disclosure of Psychotherapy Notes

A covered entity must obtain an individual's authorization to use or disclose psychotherapy notes with the following exceptions:

- The covered entity who originated the notes may use them for treatment; or
- A covered entity may use or disclose, without an individual's authorization, the psychotherapy notes, for its own training, and to defend itself in legal proceedings brought by the individual; for DHHS to investigate or determine the covered entity's compliance with the Privacy Final Rule; to avert a serious and imminent threat to public health or safety; to a health oversight agency for lawful oversight of the originator of the psychotherapy notes; or for the lawful activities of a coroner or medical examiner or as required by law.

Disclosure of Health Information for Marketing Purposes

Marketing is any communication about a product or service that encourages recipients to purchase or use the product or service. The Privacy Rule carves out the following health-related disclosure activities from this definition of marketing:

- Communications to describe health-related products or services, or payment for them, provided by or included in a benefit plan of the covered entity making the communication;
- Communications about participating providers or suppliers in a provider or health plan network, replacement of or enhancements to a health plan, and health-related products or services available only to a health plan's enrollees that add value to, but are not part of, the benefits plan;
- Communications for treatment of the individual; and
- Communications for case management or care coordination for the individual, or to direct or recommend alternative treatments, therapies, healthcare providers or suppliers, or care settings to the individual.

Marketing also is an arrangement between a covered entity and any other entity whereby the covered entity discloses protected health information, in exchange for direct or indirect remuneration, for the other entity to communicate about its own products or services encouraging the use or purchase of those products or services.

A covered entity must obtain an authorization to use or disclose protected health information for marketing, except for face-to-face marketing communications between a covered entity and an individual, and for a covered entity's provision of promotional gifts of nominal value. However, no authorization is needed to make a communication that falls within one of the exceptions to the marketing definition. An authorization for marketing that involves the covered entity's receipt of direct or indirect remuneration from a third party must reveal that fact.

Limiting Use and Disclosure to the Minimum Necessary

A central aspect of the Privacy Final Rule is the principle of minimum necessary use and disclosure. A covered entity must make reasonable efforts to use, disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the use, disclosure, or request. A covered entity must develop and implement policies and procedures to reasonably limit uses and disclosures to the minimum necessary. When the minimum necessary standard applies to a use or disclosure, a covered entity may not use, disclose, or request the entire medical

record for a particular purpose, unless it can specifically justify the whole record as the amount reasonably needed for the purpose.

The minimum necessary requirement is not imposed in any of the following circumstances:

- Disclosure to, or a request by, a healthcare provider or suppliers for treatment;
- Disclosure to an individual who is the subject of the information, or the individual's personal representative;
- Use or disclosure made pursuant to an authorization;
- Disclosure to DHHS for complaint investigation, compliance review, or enforcement;
- Use or disclosure that is required by law; or
- Use or disclosure required for compliance with the HIPAA Transactions Rule or other HIPAA Administrative Simplification Rules.

Restricting Access and Use

For internal uses, a covered entity must develop and implement policies and procedures that restrict access and uses of protected health information based on the specific roles of the members of its workforce. These policies and procedures must identify the persons, or classes of persons, in the workforce who need access to protected health information to carry out their duties, the categories of protected health information to which access is needed, and any conditions under which they need the information to do their jobs.

Limiting Disclosure Information

Covered entities must establish and implement policies and procedures (which may be standard protocols) for *routine, recurring disclosures, or requests for disclosures*, that limits the protected health information disclosed to that which is the minimum amount reasonably necessary to achieve the purpose of the disclosure. Individual review of each disclosure is not required. For non-routine, non-recurring disclosures, or requests for disclosures that it makes, covered entities must develop criteria designed to limit disclosures to the information reasonably necessary to accomplish the purpose of the disclosure and review each of these requests individually in accordance with the established criteria.

Reasonable Reliance Standard

If another covered entity makes a request for protected health information, a covered entity may rely, if reasonable under the circumstances, on the request as complying with this minimum necessary standard. Similarly, a covered entity may rely upon requests as being the minimum necessary protected health information from:

- A public official;
- A professional (such as an attorney or accountant) who is the covered entity's business associate, seeking the information to provide services to or for the covered entity; or
- A researcher who provides the documentation or representation required by the Privacy Final Rule for research.

Privacy Practices Notice and Other Individual Rights

Each covered entity, with certain exceptions, must provide a Privacy Practices Notice. The Privacy Final Rule requires that the notice contain certain elements to include:

- A description of the ways in which the covered entity may use and disclose protected health information;
- A description of the covered entity's duties to protect privacy, to provide the notice of privacy practices, and to abide by the terms of the current notice;
- A description of the individual's rights, including the right to submit complaints to DHHS and to the covered entity if he or she believes his or her privacy rights have been violated;
- A point of contact for further information and for making complaints to the covered entity (covered entities must act in accordance with their notices); and

- Specific distribution requirements for direct treatment providers, all other healthcare providers and suppliers, and health plans.

Privacy Practices Notice Distribution

As of April 14, 2003, any covered healthcare provider having a *direct treatment relationship* with individuals must provide a Privacy Practices Notice to patients as follows:

- Not later than the first service encounter by personal delivery (for patient visits), by automatic and contemporaneous electronic response (for electronic service delivery), and by prompt mailing (for telephonic service delivery);
- By posting the notice at each service delivery site in a clear and prominent place where people seeking service may reasonably be expected to be able to read the notice; and
- In emergency treatment situations, the provider must furnish its notice as soon as practicable after the emergency abates.

Covered entities, whether *direct treatment providers, indirect treatment providers* (such as laboratories), or *health plans* must supply notice to anyone on request. A covered entity must also make its notice electronically available on any website it maintains for customer service or benefits information.

Acknowledgement of Notice Receipt

A covered healthcare provider with a *direct treatment relationship* with individuals must make a good faith effort to obtain written acknowledgement from patients of receipt of the Privacy Practices Notice. The Privacy Final Rule does not prescribe any particular content for the acknowledgement. The provider must document the reason for any failure to obtain the patient's written acknowledgement. The provider is relieved of the need to request acknowledgement in an emergency treatment situation.

Individual Access to Health Information

Except in certain circumstances, individuals have the right to review and obtain a copy of his or her protected health information in a covered entity's designated record set. The designated record set is that group of records maintained by or for a covered entity. This record set is used, in whole or part, to make decisions about individuals. It may also serve as a provider's or supplier's medical and billing records about individuals or a health plan's enrollment, payment, claims adjudication, and case or medical management record systems.

The Privacy Final Rule makes exceptions from the right of access for the following protected health information:

- Psychotherapy notes;
- Information compiled for legal proceedings;
- Laboratory results to which the Clinical Laboratory Improvement Act (CLIA) prohibits access; or
- Information held by certain research laboratories.

For information included within the right of access, covered entities may deny access to an individual in certain specified situations, such as when a healthcare professional believes access could cause harm to the individual or another. In such situations, the individual must be given the right to have such denials reviewed by a licensed healthcare professional for a second opinion. Covered entities may impose reasonable, cost-based fees for the cost of copying and postage.

Accounting of Health Information Disclosure

Individuals have a right to an accounting of the disclosures of their protected health information by a covered entity or the covered entity's business associates. The maximum disclosure accounting period is the six years immediately preceding the accounting request, except a covered entity is not obligated to account for any disclosure made before the Privacy Final Rule compliance date.

The Privacy Final Rule does not require accounting for disclosures:

- For treatment, payment, or healthcare operations;
- To the individual or the individual's personal representative;
- For notification of or to persons involved in an individual's health care or payment for health care, for disaster relief, or for facility directories;
- Pursuant to an authorization;
- Of a limited data set;
- For national security or intelligence purposes;
- To correctional institutions or law enforcement officials for certain purposes regarding inmates or individuals in lawful custody; or
- Incident to otherwise permitted or required uses or disclosures.

Accounting for disclosures to health oversight agencies and law enforcement officials must be temporarily suspended on its written representation that an accounting would likely impede its activities.

Restriction Request

Individuals have the right to request that a covered entity restrict use or disclosure of protected health information for treatment, payment or healthcare operations, disclosure to persons involved in the individual's health care or payment for health care, or disclosure to notify family members or others about the individual's general condition, location, or death. A covered entity is under no obligation to agree to requests for restrictions. A covered entity that does agree must comply with the agreed restrictions, except for purposes of treating the individual in a medical emergency.

Amendment of Protected Health Information

The Privacy Final Rule gives individuals the right to have covered entities amend their protected health information in a designated record set when that information is inaccurate or incomplete. If a covered entity accepts an amendment request, the covered entity must make reasonable efforts to provide the amendment to persons identified as needing the amendment, and to persons that the covered entity knows might rely on the information to the individual's detriment. If the request is denied, covered entities must provide the individual with a written denial and allow the individual to submit a statement of disagreement for inclusion in the record. The Privacy Final Rule specifies processes for requesting and responding to a request for amendment. A covered entity must amend protected health information in its designated record set upon receipt of notice to amend from another covered entity.

Confidential Communications Requirements

Health plans and covered healthcare providers and suppliers must permit individuals to request an alternative means or location for receiving communications of protected health information by means other than those that the covered entity typically employs. For example, an individual may request that the provider or supplier communicate with the individual through a designated address or phone number. Similarly, an individual may request that the provider or supplier send communications in a closed envelope rather than a postcard.

Health plans must accommodate reasonable requests if the individual indicates that the disclosure of all or part of the protected health information could endanger the individual. The health plan may not question the individual's statement of endangerment. Any covered entity may condition compliance with a confidential communication request on the individual specifying an alternative address or method of contact and explaining how any payment will be handled.

ADMINISTRATIVE REQUIREMENTS FOR IMPLEMENTING HIPAA STANDARDS

In implementing HIPAA standards, a covered entity must fulfill many requirements in its organization and policies. These requirements

are set in place to ensure that HIPAA standards are maintained while the information remains protected.

Privacy Policies and Procedures

A covered entity must develop and implement written privacy policies and procedures that are consistent with the Privacy Final Rule.

Privacy Policy Compliance Information
For additional information on complying with privacy policies and procedures, contact the OCR Privacy Hotline at 1-866-627-7748.

Privacy Personnel

A covered entity must designate a privacy officer responsible for developing and implementing its privacy policies and procedures, and a contact person or contact office responsible for receiving complaints and providing individuals with information on the covered entity's privacy practices.

Workforce Training and Management

Workforce members include employees, volunteers, trainees, and may also include other persons whose conduct is under the direct control of the entity (whether or not they are paid by the entity). A covered entity must train all workforce members on its privacy policies and procedures, as necessary and appropriate for them to carry out their functions. A covered entity must have and apply appropriate sanctions against workforce members who violate its privacy policies and procedures or the Privacy Final Rule.

Mitigation

A covered entity must mitigate, to the extent practicable, any harmful effect it learns was caused by use or disclosure of protected health information by its workforce, or its business associates, in violation of its privacy policies and procedures or the Privacy Final Rule.

Data Safeguards

A covered entity must maintain reasonable and appropriate administrative, technical, and physical safeguards to prevent intentional or unintentional use or disclosure of protected health information in violation of the Privacy Final Rule, and to limit its incidental use and disclosure pursuant to otherwise permitted or required use or disclosure. For example, such safeguards might include shredding documents containing protected health information before discarding them, securing medical records with lock and key or pass code, and limiting access to keys or pass codes.

Complaints

A covered entity must have procedures for individuals to complain about its compliance with its privacy policies and procedures and the Privacy Final Rule. The covered entity must explain those procedures in its privacy practices notice.

Among other things, the covered entity must identify to whom individuals can submit complaints and advise that complaints also can be submitted to the Secretary of DHHS.

Retaliation and Waiver

A covered entity may not retaliate against a person for exercising rights provided by the Privacy Final Rule, for assisting in an investigation by DHHS or another appropriate authority, or for opposing an act or practice that the person believes in good faith violates the Privacy Final Rule. A covered entity may not require an individual to waive any right under the Privacy Final Rule as a condition for obtaining treatment, payment, and enrollment or benefits eligibility.

Documentation and Record Retention

A covered entity must maintain, until six years after the later of the date of its creation or last effective date, its privacy policies and procedures, its privacy practices notices, disposition of complaints, and other actions, activities, and designations that the Privacy Final Rule requires to be documented.

OTHER PROVISIONS

The Privacy Final Rule also addresses covered entities who fall under contain circumstances that require then to have a legal representative who can act on their behalf.

Personal Representatives

The Privacy Final Rule requires a covered entity to treat a “personal representative” the same as the individual, with respect to uses and disclosures of the individual's protected health information, as well as the individual's rights under the Privacy Final Rule. A personal representative is a person legally authorized to make healthcare decisions on an individual's behalf or to act for a deceased individual or the estate. The Privacy Final Rule permits an exception when a covered entity has a reasonable belief that the personal representative may be abusing or neglecting the individual, or that treating the person as the personal representative could otherwise endanger the individual.

Special Case: Minors

In most cases, parents are the personal representatives for their minor children. Therefore, in most cases, parents can exercise individual rights, such as access to the medical record, on behalf of their minor children. In certain exceptional cases, the parent is not considered the personal representative. In these situations, the Privacy Final Rule defers to state and other law to determine the rights of parents to access and control the protected health information of their minor children. If state and other law is silent concerning parental access to the minor's protected health information, a covered entity has discretion to provide or deny a parent access to the minor's health information, provided the decision is made by a licensed healthcare professional in the exercise of professional judgment.

HOW DOES HIPAA ENFORCE STANDARDS?

CMS has been designated by the Secretary of DHHS to enforce all of the HIPAA administrative simplifications provisions, with the exception of the privacy standards. This includes transaction and code set standards, and the security standards and identifier standards when they go into effect. The DHHS OCR is responsible for enforcement of the privacy provisions.

CMS will focus on obtaining voluntary compliance and use a complaint-driven approach for enforcement of HIPAA's electronic transactions and code sets provisions. When CMS receives a complaint about a covered entity, it will notify the entity in writing that a complaint has been filed. Following notification from CMS, the entity will have the opportunity to:

(1) Demonstrate compliance;
(2) Document its good faith efforts to comply with the standards; and/or
(3) Submit a corrective action plan.

Demonstrating Compliance - Covered entities will be given an opportunity to demonstrate to CMS that they submitted compliant transactions.

Good Faith Policy - CMS's approach will utilize the flexibility granted in section 1176(b) of the Social Security Act to consider good faith efforts to comply when assessing individual complaints. Under section 1176(b), DHHS may not impose a civil money penalty where the failure to comply is based on reasonable cause, is not due to willful neglect, and the failure to comply is cured with a 30-day period. DHHS has the authority under the statute to extend the period within which a covered entity may cure the noncompliance

"based on the nature and extent of the failure to comply."

CMS recognizes that transactions often require the participation of two covered entities and that noncompliance by one covered entity may put the second covered entity in a difficult position. Therefore, during the period immediately following the compliance date, CMS intends to

look at both covered entities' good faith efforts to come into compliance with the standards in determining, on a case-by-case basis, whether reasonable cause for the noncompliance exists and, if so, the extent to which the time for curing the noncompliance should be extended.

CMS will not impose penalties on covered entities that deploy contingencies (in order to ensure the smooth flow of payments) if they have made reasonable and diligent efforts to become compliant and, in the case of health plans, to facilitate the compliance of their trading partners. Specifically, as long as a health plan can demonstrate to CMS its active outreach/testing efforts, it can continue processing payments to providers and suppliers. In determining whether a good faith effort has been made, CMS will place a strong emphasis on sustained actions and demonstrable progress.

Indications of good faith might include, for example, such factors as:

- Increased external testing with trading partners.
- Lack of availability of, or refusal by, the trading partner(s) prior to October 16, 2003, to test the transaction(s) with the covered entity whose compliance is at issue.
- In the case of a health plan, concerted efforts in advance of the October 16, 2003, and continued efforts afterwards to conduct outreach and make testing opportunities available to its provider/supplier community.

While there are many examples of complaints that CMS may receive, the following example illustrates how CMS expects the process to work.

Example: A complaint is filed against an otherwise compliant health plan that accepts and processes both compliant and non-compliant transactions while working to help its providers and suppliers achieve compliance.

In this situation, CMS would:

(1) Notify the plan of the complaint;
(2) Based on the plan's response to the notification, evaluate the plan's efforts to help its noncompliant providers and suppliers come into compliance; and
(3) If it is determined that the plan had demonstrated good faith and reasonable cause for its non-compliance, not impose a penalty for the period of time CMS determines is appropriate, based on the nature and extent of the failure to comply.

For example, CMS would examine whether the health plan undertook a course of outreach actions to its trading partners on awareness and testing, with particular focus on the actions that occurred prior to October 16, 2003. Similarly, healthcare providers and suppliers should be able to demonstrate that they took actions to become compliant prior to October 16, 2003. If CMS determines that reasonable and diligent efforts have been made, the cure period for noncompliance would be extended at the discretion of the Government. Furthermore, CMS will continue to monitor the covered entity to ensure that its sustained efforts bring progress towards compliance. If continued progress is not made, CMS will step up its enforcement efforts towards that covered entity.

Organizations that have exercised good faith efforts to correct problems and implement the changes required to comply with HIPAA should be prepared to document them in the event of a complaint being filed. This flexibility will permit health plans to mitigate unintended adverse effects on covered entities' cash flow and business operations during the transition to the

HIPAA Standards Enforcement Information
Additional information on CMS' enforcement of HIPAA standards is available at http://www.cms.hhs.gov/ocr/combinedregtext.pdf on the CMS website.

standards, as well as on the availability and quality of patient care.

Corrective Action Plan (CAP) - After October 16, 2003, in addition to possible fines and penalties imposed, CMS will expect non-compliant covered entities to submit plans to achieve compliance in a manner and time acceptable to the Secretary.

REFERENCE A: PROVIDER SPECIALTY CODES

Please note that all information listed below was accurate per the Centers for Medicare & Medicaid Services (CMS) website at the time of printing; however, this information is subject to change.

The following provider specialty codes are recognized by CMS as of April 1, 2003. Updates to this list may be located at http://www.cms.hhs.gov/providers/enrollment on the Web:

01 General Practice
02 General Surgery
03 Allergy/Immunology
04 Otolaryngology
05 Anesthesiology
06 Cardiology
07 Dermatology
08 Family Practice
09 Interventional Pain Management
10 Gastroenterology
11 Internal Medicine
12 Osteopathic Manipulative Therapy
13 Neurology
14 Neurosurgery
16 Obstetrics/Gynecology
18 Opthalmology
19 Oral Surgery (Dentists only)
20 Orthopedic Surgery
22 Pathology
24 Plastic & Reconstructive Surgery
25 Physical Medicine & Rehabilitation
26 Psychiatry
28 Colorectal Surgery
29 Pulmonary Disease
30 Diagnostic Radiology
32 Anestheologist Assistant
33 Thoracic Surgery
34 Urology
35 Chiropractor
36 Nuclear Medicine
37 Pediatric Medicine
38 Geriatric Medicine
39 Nephrology
40 Hand Surgery
41 Optometry
42 Certified Nurse Midwife
43 Certified Registered Nurse Anesthetists (CRNA) Anesthesia Assistant
44 Infectious Disease
45 Mammography Screening Center
46 Endocrinology

47 Independent Diagnostic Testing Facilities (IDTF)
48 Podiatry
49 Ambulatory Surgical Center
50 Nurse Practitioner (NP)
51 Medical Supply Co. w/Certified Orthotist
52 Medical Supply Co. w/Certified Prosthetist
53 Medical Supply Co. w/Certified Prosthetist-Orthotist
54 Medical Supply Co. not included in Specialties 51-53
55 Individually Certified Orthotist
56 Individually Certified Prosthetist
57 Individually Certified Prosthetist-Orthotist
58 Medical Supply Company w/ Pharmacist
59 Ambulance Service (Private)
60 Public Health/Welfare Agency
61 Voluntary Health or Charitable Agency
62 Psychologist
63 Portable X-Ray Supplier
64 Audiologist (Billing Independently)
65 Physical Therapist (Private Practice)
66 Rheumatology
67 Occupational Therapist (Private Practice)
68 Clinical Psychologist
69 Clinical Laboratory (Billing Independently)
70 Multi-Specialty Clinic or Group Practice
71 Dietitians/Nutritionists
72 Pain Management
73 Mass Immunization Roster Billers
74 Radiation Therapy Center
75 Slide Preparation Facility
76 Peripheral Vascular Disease
77 Vascular Surgery
78 Cardiac Surgery
79 Addiction Medicine
80 Licensed Clinical Social Worker
81 Critical Care (Intensivists)
82 Hematology
83 Hematology/Oncology
84 Preventive Medicine
85 Maxillofacial Surgery
86 Neuropsychiatry
87 All Other Suppliers (Drug & Dept. Store, etc.)
88 Unknown Supplier/Provider
89 Certified Clinical Nurse Specialist
90 Medical Oncology
91 Surgical Oncology
92 Radiation Oncology
93 Emergency Medicine
94 Interventional Radiology
96 Optician
97 Physician Assistant

98 Gynecological/Oncology
99 Unknown Physician Specialty
A0 Hospital
A1 Skilled Nursing Facility
A2 Intermediate Care Nursing Facility
A3 Other Nursing Facility
A4 Home Health Agency
A5 Pharmacy
A6 Medical Supply Company w/ Respiratory Therapist
A7 Department Store
A8 Grocery Store

REFERENCE B: FORM CMS-1500

CLAIM COMPLETION REQUIREMENTS FOR FORM CMS-1500

The Form CMS-1500 health insurance claim form is the prescribed form for billing Medicare Part B covered services by non-institutional providers and suppliers. The Form CMS-1500 can be used for both assigned and non-assigned claims, and is sometimes referred to as the American Medical Association (AMA) Form. It can be purchased in any version required (i.e., single sheet, snap-out, continuous, etc.) from the U.S. Government Printing Office (GPO), who can be contacted at 202-512-1800. An electronic version is also available at http://www.cms.hhs.gov/providers/edi/edi5.asp on the Web.

When filing Medicare Part B paper claims, providers are encouraged to type or machine-print all mandated claim fields on Form CMS-1500 and mail the claim to the local carrier. Certain carriers process claims using Optical Character Recognition (OCR), which is an automated scanning process similar to scanners that read price labels in grocery stores. OCR claims processing is faster and more accurate than systems requiring manual input. However, to work properly, OCR must accurately read and interpret the characters entered in each field. It reads only typed or machine-printed data. Some carriers may require that only an original, red-ink Form CMS-1500 may be submitted because their Optical Character Recognition (OCR) software is unable to recognize black and white photocopies.

After the claims information is scanned, it is transmitted to the claims processing system, where it is validated and compared to other data until final processing occurs. To ensure accurate, quick claim processing, the following guidelines should be followed:

- Do not staple, clip, or tape anything to the Form CMS-1500 claim form;
- Place all necessary documentation in the envelope with the Form CMS-1500 claim form;
- Put the patient's name and Medicare number on each piece of documentation submitted;
- Use dark ink;
- Use only upper-case (CAPITAL) letters;
- Use 10 or 12 pitch (pica) characters and standard dot-matrix fonts;
- Do not mix character fonts on the same form;
- Do not use italics or script;
- Avoid using old or worn print bands or ribbons;
- Do not use dollar signs, decimals, or punctuation;
- Enter all information on the same horizontal plane within the designated field;
- Do not print, hand-write, or stamp any extraneous data on the form;
- Use only lift-off correction tape to make corrections;
- Ensure data is in the appropriate field and does not overlap into other fields;
- Remove pin-fed edges at side perforations; and
- Use only an original red-ink-on-white-paper Form CMS-1500 claim form.

Submission of paper claims that do not meet the carrier's requirements may delay payments.

EXAMPLE FORM CMS-1500

An example of the Form CMS-1500 is included within this section. A Key explaining how to enter date information into the Form CMS-1500 is included in Table B-1.

Table B-1. Key to Form CMS-1500.

Key	Description
MM	Month (e.g., December = 12)
DD	Day (e.g., Dec15 = 15)
YY	2 position year (e.g., 1998 = 98)
YYYY	4 position year (e.g., 1998 = 1998)
(MM|DD|YY) or (MM|DD|YYYY)	Indicate that a space must be reported between month, day, and year (e.g., 12|15|98 or 12|15|1998). This space is delineated by a dotted verticle line on the Form CMS01500.
(MMDDYY) or (MMDDYYYY)	Indicates that no space must be reported between month, day, and year (e.g., 121598 or 12151998). The date must be recorded as one continuous number.

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM | DD | YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM | DD | YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM | DD | YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM | DD | YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM | DD | YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM | DD | YY FROM TO MM | DD | YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM | DD | YY FROM TO MM | DD | YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____ 3. ____

2. ____ 4. ____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1											
2											
3											
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

Updated instructions for completing the form may be found at http://www.cms.hhs.gov/manuals/104_claims/clm104c26.pdf on the Web.

Item	Information To Be Entered	Notes
Patient and Insured Information		
Item 1 Health Insurance Coverage	Check the box next to the insurance option applicable to this claim.	
Item 1a Insurance ID Number	Enter the patient's Medicare Health Insurance Claim Number (HICN) whether Medicare is the primary or secondary payer.	
Item 2 Patient's Name	Enter the patient's last name, first name, and middle initial (if any), as shown on the patient's Medicare card.	
Item 3 Patient's Birth Date and Sex	Enter the patient's eight-digit birth date (MM|DD|YYYY) and check the appropriate box to indicate the sex of the patient.	The following codes are used to indicate the patient's sex: F = Female; M = Male
Item 4 Insured's Name	**If Medicare is secondary to other insurance**, either through a patient's or spouse's employment or any other source, list the name of the insured. Enter the patient's last name, first name, and middle initial (if any). When the patient and insured are the same, enter "SAME". **If Medicare is primary, leave blank.**	
Item 5 Patient's Address	Enter the patient's mailing address and telephone number.	
Item 6 Patient's Relationship to the Insured	**If Item 4 was completed**, check the appropriate box to indicate the patient's relationship to the insured (self, spouse, child, other).	
Item 7 Insured's Address	**If Items 4-11 are completed**, enter the insured's address and telephone number. If this address is the same as the patient's, enter "SAME".	
Item 8 Patient Status	Check the appropriate box to indicate the patient's marital status (single, married, or other). Check the appropriate box to indicate the patient's employment status (employed, full-time student, or part-time student).	

Item	Information To Be Entered	Notes
Patient and Insured Information (Con't)		
Item 9 Other Insured's Name	**If the Medigap enrollee's name is different from the insured's name (as entered in Item 2)**, enter the Medigap policy enrollee's last name, first name, and middle initial (if any). **Otherwise**, enter "SAME". **If no Medigap benefits are assigned**, leave blank.	**Only participating physicians and suppliers are to complete Item 9 and its subdivisions and only when the beneficiary wishes to assign benefits under a Medigap policy to the participating physician or supplier.** In the future, this item may be used for supplemental insurance plans. **If the beneficiary has assigned their benefits under a Medigap policy to a participating physician/supplier**, participating physicians/suppliers must enter information in Items 9a-d. **If you are a participating provider of service or supplier and the beneficiary wants Medicare payment data forwarded to a Medigap insurer under a mandated Medigap transfer**, all information in Items 9, 9a, 9b, and 9d must be complete and accurate. **Otherwise**, the Medicare carrier cannot forward the claim information to the Medigap insurer. Do not list other supplemental coverage in Items 9a-d at the time a Medicare claim is filed. **If the private insurer contracts with the carrier to send Medicare claim information electronically**, other supplemental claims will be automatically forwarded to the private insurer. **If the private insurer has not contracted to send claim information electronically**, the beneficiary must file own supplemental claim.

Item	Information To Be Entered	Notes
Patient and Insured Information (Con't)		
Item 9a Other Insured's Policy or Group Number	Enter the Medigap insured's policy and/or group number, preceded by "MEDIGAP", "MG", or "MGAP".	Item 9d must be completed if a policy and/or group number was entered in Item 9a.
Item 9b Other Insured's Date of Birth and Sex	Enter the Medigap insured's eight-digit birth date (MM|DD|YYYY) and check the appropriate box to indicate the insured's sex.	The following codes are used to indicate the patient's sex: F = Female; M = Male
Item 9c Employer's Name or School Name	**If Item 9d contains a Medigap PAYERID number**, leave blank. **Otherwise**, enter the claims processing address of the Medigap insurer. Use an abbreviated street address, a two letter postal abbreviation, and the ZIP Code copied from the Medigap insured's Medigap ID card.	**Example:** 1257 Anywhere Street Baltimore MD, 21204 Would be entered as "1257 Anywhere St MD 21204".
Item 9d Insurance Plan Name or Program Name	**If you entered a policy and/or group number into Item 9a**, you must enter the nine-digit PAYERID number of the Medigap insurer. If no PAYERID number exists, enter the Medigap insurance program or plan name.	
Item 10a Employment (Current or Previous)?	Check Yes or No to indicate if the claim is covered under the patient's current or previous employment insurance.	If "Yes" is checked, this indicates that Medicare may be secondary to other insurance. Enter primary insurance information in Item 11.
Item 10b Auto Accident? Place (State)	Check Yes or No to indicate if the claim was a result of an auto accident. If checking Yes, enter the state postal abbreviation (e.g., VA for Virginia) in which the accident occurred.	
Item 10c Other Accident?	Check Yes or No to indicate if the claim is the result of an accident other than an auto accident.	
Item 10d Reserved for Local Use	**If the patient is entitled to Medicaid**, enter the patient's Medicaid number, preceded by "MCD".	

Item	Information To Be Entered	Notes
Patient and Insured Information (Con't)		
Item 11 Insured's Policy Group or FECA Number	**If there is insurance primary to Medicare (i.e., Medicare is secondary)**, enter the insured's policy or group number and proceed to Items 11a-c. **If there is no insurance primary to Medicare (i.e., Medicare is primary)**, enter "NONE" and proceed to Item 12. **If the insured reports a terminating event with regard to insurance that had been primary to Medicare (e.g., insured retired)**, enter "NONE" and proceed to Item 11b.	**THIS ITEM MUST BE COMPLETED.** By completing this item, the physician/supplier acknowledges having made a good faith effort to determine if Medicare is the primary or secondary payer.
Item 11a Insured's Date of Birth	Enter insured's eight-digit birth date (MM|DD|YYYY) and sex if different than Item 3 input.	
Item 11b Employer's Name or School Name	Enter the employer's name, if applicable. If there is a change in the insured's insurance status, enter either a six-digit (MM|DD|YY) or eight-digit (MM|DD|YYYY) change in status date, followed by a word describing the change.	If the person has retired, put "RETIRED" before the date.
Item 11c Insurance Plan Name or Program Name	Enter the nine-digit PAYER ID number of the primary insurer. If no Payer ID number exists, enter the complete primary payer's program or plan name. If the primary payer's Explanation of Benefits (EOB) does not contain the claims processing address, record the primary payer's claims processing address directly on the EOB.	
Item 11d	Leave blank. Not required by Medicare.	
Item 12 Patient's Signature	The patient or their authorized representative must enter a signature* in Item 12 unless a signature and/or a computer-generated signature is on file. If a signature is already on file, enter "SOF" or "SIGNATURE ON FILE". The signature authorizes release of medical information necessary to process the claim. Enter a date in either a six-digit	In lieu of signing the claim, the patient may provide the provider, physician, and/or supplier a signed statement to keep on file. If the patient is physically or mentally unable to sign, an authorized representative may sign on the patient's behalf. After the statement's signature line, the representative must write "by", followed by their name, address, relationship to

Item	Information To Be Entered	Notes
Patient and Insured Information (Con't)		
Item 12 (con't) Patient's Signature	(MM|DD|YY), eight-digit (MM|DD|YYYY), or alphanumeric (January 1, 1998) format. *When an illiterate or physically handicapped enrollee signs by mark (i.e., with an "X"), a witness must enter his or her name and address next to the mark.	the patient, and the reason the patient cannot sign. This authorization is effective indefinitely unless the patient or patient's representative revokes the arrangement.
Item 13 Insured's or Authorized Person's Signature	**If Item 9 contains Medigap information**, the patient or their authorized representative must sign and date Item 13 to authorize payment of mandated Medigap benefits or the signature must be on file as a separate Medigap authorization.	The Medigap assignment on file in the participating provider of service/supplier's office must be insurer-specific. It may state that the authorization applies to all occasions of service until it is revoked.

ENTERING PROVIDER OF SERVICE OR SUPPLIER INFORMATION

Item	Information To Be Entered	Notes
Provider of Service or Supplier Information		
Item 14 Date of Current: Illness (First Symptom); Injury (Accident); or Pregnancy (LMP)	Enter either a six-digit (MM|DD|YY) or eight-digit (MM|DD|YYYY) date of current illness, injury, or pregnancy. **For chiropractic services**, enter either a six-digit (MM|DD|YY) or eight-digit (MM|DD|YYYY) date of the initiation of the course of treatment, then enter either a six-digit (MM|DD|YY) or eight-digit (MM|DD|YYYY) date in Item 19.	
Item 15 If Patient Has Had Same or Similar Illness Give First Date	Leave blank. Not required by Medicare.	
Item 16 Dates Patient Unable to Work in Current Occupation	If the patient is employed and unable to work in current occupation, enter either a six-digit (MM|DD|YY) or eight-digit (MM|DD|YYYY) date range to indicate when the patient is unable to work.	An entry in this field may indicate employment-related insurance coverage.

Item	Information To Be Entered	Notes
Provider of Service or Supplier Information (Con't)		
Item 17 Name of Referring Physician or Other Source	Enter the name of the referring or ordering physician for an item or service, if applicable. **If a physician refers a patient to a surgeon**, the surgeon's name and National Provider Identifier (NPI) must be entered into Items 17 and 17a. If a physician extender or other limited licensed practitioner refers a patient for consultative services, the name and NPI of the supervising physician must be entered into Items 17 and 17a. **When a patient is referred to a physician who also orders and performs a diagnostic service**, a separate claim form is required for the diagnostic service. Enter the original ordering/referring physician's name and NPI into Items 17 and 17a of the FIRST claim form. Enter the performing physician's name and NPI into Items 17 and 17a of the SECOND claim form.	**When a claim involves multiple referring and/or ordering physicians**, a separate Form CMS-1500 must be submitted for EACH ordering/referring physician. All claims for Medicare-covered services and items that result from a physician's order or referral must include the ordering/referring physician's name and NPI. This includes parenteral and enteral nutrition, immunosuppressive drug claims, and the following: ❖ Diagnostic laboratory services; ❖ Diagnostic radiology services; ❖ Consultative services; and ❖ Durable Medical Equipment (DME). The NPI system was adopted as of January 22, 2004. The final rule establishing the NPI as the standard unique health identifier will be effective as of May 23, 2005.
Item 17a ID Number of Referring Physician	Enter the CMS-assigned National Provider Identifier (NPI) of the referring/ordering physician listed in Item 17. Enter only the seven-digit base number and the one-digit check digit.	If the ordering/referring physician has not been assigned an NPI, one of the following surrogate NPIs must be used: ❖ RES00000 - for interns and residents who have not been assigned an NPI; ❖ RET00000 - for retired physicians who were not issued an NPI; ❖ VAD00000 - for physicians serving in the Veterans Health Administration (VHA) or the U.S. Armed Services; ❖ PHS00000 - for physicians serving in the Public Health or Indian Health Services; ❖ NPP00000 - for state-licensed nurse practitioners, clinical nurse specialists, or any other non-physician practitioner authorized

Item	Information To Be Entered	Notes
Provider of Service or Supplier Information (Con't)		
Item 17a (con't) ID Number of Referring Physician		to order medical services or refer patients without approval or collaboration from a supervising physician; or ❖ OTH00000 - for when the ordering/referring physician has not been assigned an NPI and does not meet any of the above criteria. The NPI system was adopted as of January 22, 2004. The final rule establishing the NPI as the standard unique health identifier will be effective as of May 23, 2005.
Item 18 Hospitalization Dates Related to Current Services	Enter either a six-digit (MM|DD|YY) or eight-digit (MM|DD|YYYY) date range to indicate when a medical service is furnished as a result of, or subsequent to, a related hospitalization.	
Item 19 Reserved for Local Use	Enter either a six-digit (MM|DD|YY) or an eight-digit (MM|DD|YYYY) date the patient was last seen and the PIN [National Provider Identifier (NPI) when it becomes effective] of his or her attending physician when an independent physical or occupational therapist or physician providing routine foot care submits claims. For physical and occupational therapists, entering this information certifies that the required physician certification (or recertification) is being kept on file (see Chapter 15 of the *Medicare Benefits Policy Manual*). **When submitting for chiropractic services (if an X-ray, rather than a physical examination was the method used to demonstrate the subluxation)**, enter either a six-digit (MM|DD|YY) or an eight-digit (MM|DD|YYYY) X-ray date for chiropractor services. By entering an X-ray date and the initiation date for course of chiropractic treatment in Item	Item 19 can contain up to three conditions per claim. Additional conditions must be reported on a separate Form CMS-1500. The NPI system was adopted as of January 22, 2004. The final rule establishing the NPI as the standard unique health identifier will be effective as of May 23, 2005. Enter a concise description of an "unlisted procedure code" or a NOC code if one can be given within the confines of this box. Otherwise, an attachment must be submitted with the claim.

Item	Information To Be Entered	Notes
Provider of Service or Supplier Information (Con't)		
Item 19 (con't) Reserved for Local Use	14, the contractor is certifying that all the relevant information requirements (including level of subluxation) per Chapter 15 of the *Medicare Benefits Policy Manual*, are on file, along with the appropriate X-ray and all are available for carrier review. **When submitting a Not Otherwise Classified (NOC) drug claim**, enter the drug's name and dosage. **When modifier -99 (multiple modifiers) is entered in Item 24d**, enter all applicable modifiers. **If modifier -99 is entered on multiple line items of a single claim form**, all applicable modifiers for each line item containing a -99 modifier should be listed as follows: 1=(mod), where the number 1 represents the line item and "mod" represents all modifiers applicable to the referenced line item. **When an independent laboratory renders an EKG tracing or obtains a specimen from a homebound or institutionalized patient**, enter the statement "Homebound". Refer to Chapters 15 and 16 of the Medicare *Benefit Policy Manual*, and Chapter 5 of the *Medicare General Information, Eligibility, and Entitlement Manual* for the definition of "homebound" and a more complete definition of a medically necessary laboratory service to a homebound or an institutional patient. **When the beneficiary absolutely refuses to assign benefits to a participating provider**, enter the statement, "Patient refuses to assign benefits". In this case, no payment may be made on the claim.	

Item	Information To Be Entered	Notes
Provider of Service or Supplier Information (Con't)		
Item 19 (con't) Reserved for Local Use	**When billing services involving the testing of a hearing aid(s) are used to obtain intentional denials when other payers are involved**, enter the statement, "Testing for hearing aid". **When dental examinations are billed**, enter the specific surgery for which the exam is being performed. Enter the specific name and dosage amount when low osmolar contrast material is billed, but only if Health Care Common Procedure Coding System (HCPCS) codes do not cover them. **When providers share post-operative care**, enter a six-digit (MM|DD|YY) or an eight-digit (MM|DD|YYYY) assumed and/or relinquished date for a global surgery claim. **If submitting a national emphysema treatment trial claim**, enter Demonstration ID number "30". **If the physician is performing a purchased interpretation of a diagnostic test**, enter the PIN (or NPI when effective). Refer to Chapter 1 of the Medicare Claims Processing Manual for additional information). Report the interpreting physician's PIN proceeded by a "PI" indicator (i.e., PI999999).	
Item 20 Outside Lab and $ Charges	**When billing for diagnostic tests subject to purchase price limitations**, check the "Yes" box. **If no purchased tests are included on the claim**, check the "No" box.	"Yes" indicates that an entity other than the entity billing for the service performed the diagnostic test and Item 32 must be completed. "No" indicates that no diagnostic checks are included on the claim.
Item 21 Diagnosis or Nature of Illness or Injury	Enter the patient's diagnosis/condition using up to four codes in priority order (primary, secondary condition). All physician specialties must use an	When billing for multiple purchased diagnostic tests, each test must be submitted on a separate claim form.

Item	Information To Be Entered	Notes
Provider of Service or Supplier Information (Con't)		
Item 21 (con't) Diagnosis or Nature of Illness or Injury	ICD-9-CM code number to the highest level of specificity.	All narrative diagnoses for non-physician specialties must be submitted on an attachment. An independent laboratory must enter a diagnosis only for limited coverage procedures. Access updated ICD-9-CM procedure and diagnosis codes billable to DMERCs at http://www.cms.hhs.gov/paymentsystems/icd9/default.asp on the Web.
Item 22 Medicaid Resubmission Code and Original Ref. No.	Leave blank. Not required by Medicare.	
Item 23 Prior Authorization Number	**For procedures requiring Professional Review Organization (PRO) prior approval**, enter the prior PRO authorization number. **When an investigational device is used in a Food and Drug Administration (FDA)-approved clinical trial**, enter the Investigational Device Exemption (IDE) number. **For physicians performing care plan oversight services**, enter the six-digit Medicare provider number of the home health agency (HHA) or hospice when Current Procedural Terminology (CPT) code 99375 or 99376 or Health Care Common Procedure Coding System (HCPCS) code G0064, G0065, or G0066 is billed. **For laboratory services billed by an entity performing Clinical Laboratory Improvement Act (CLIA) covered procedures**, enter the ten-digit CLIA certification number.	

Item	Information To Be Entered	Notes
Provider of Service or Supplier Information (Con't)		
Item 24A Date(s) of Service	Enter either a six-digit (MM|DD|YY) or eight-digit (MM|DD|YYYY) date range to indicate when the patient received each procedure, service, or supply.	
Item 24B Place of Service	Enter the appropriate Place of Service (POS) code(s) (see Reference E) for each item used or service performed.	When a service is rendered to a hospital inpatient, use the inpatient hospital code.
Item 24C Type of Service	Medicare providers are not required to complete this item.	
Item 24D Procedures, Services, or Supplies	Enter the procedures, services, or supplies using the Health Care Common Procedure Coding System (HCPCS). When applicable, show HCPCS modifiers with the HCPCS code. Enter the specific procedure code without a narrative description. When reporting a Not Otherwise Classified (NOC) code, include a narrative description in Item 19 if it will fit. Otherwise, submit the narrative in an attachment with the claim. **If modifier "-99" is entered on multiple line items of a single claim form**, all applicable modifiers for each line item containing a "-99" modifier should be listed as follows: 1=(mod), where the number 1 represents the line item and "mod" represents all modifiers applicable to the referenced line item.	
Item 24E Diagnosis Code	Enter the diagnosis code reference number as shown in Item 21 to relate the date of service and the procedures performed to the primary diagnosis. Enter only one reference number per line item.	

Item	Information To Be Entered	Notes
Provider of Service or Supplier Information (Con't)		
Item 24E (con't) Diagnosis Code	**When multiple services are performed**, enter the primary reference number for each service (either 1, 2, 3, or 4). **If two or more diagnoses are required for a procedure code (e.g., pap smears)**, reference only one of the diagnoses in Item 21.	
Item 24F $ Charges	Enter the charge for each listed service.	
Item 24G Days or Units	**When From/To dates are shown for a series of identical services/supplies in Box 24A**, enter the number of days or units. **If only one service is provided**, enter numeral "1". **If multiple services are provided**, enter the actual number provided. **For anesthesia**, enter the elapsed time (minutes). Convert hours into minutes and enter the total minutes required for this procedure. **For oxygen**, suppliers must furnish the units of oxygen contents except for concentrators and initial rental claims for gas and liquid oxygen systems.	This field is most commonly used for multiple visits, units of supplies, anesthesia minutes, or oxygen volumes. Some services require that the actual number or quantity billed be clearly indicated on the claim form (e.g., multiple ostomy or urinary supplies, medication dosages, or allergy testing procedures). Round oxygen contents as follows: ❖ For stationary gas system rentals, indicate the oxygen contents in unit multiples of 50 cubic feet, rounded to the nearest increment of 50. **Example:** If 73 cubic feet of oxygen were delivered during the rental month, the unit entry "01" would be entered to indicate the nearest 50 cubic foot increment. ❖ For stationary liquid systems, units of contents must be specified in multiples of 10 pounds of liquid contents delivered, rounded to the nearest 10-pound increment. **Example:** If 63 pounds of liquid oxygen were delivered during the

Item	Information To Be Entered	Notes
Provider of Service or Supplier Information (Con't)		
Item 24G (con't) Days or Units		applicable rental month billed, the unit entry "06" would be entered. ❖ For units of portable contents only (i.e., no stationary gas or liquid system used), round to the nearest five feet or one liquid pound, respectively.
Item 24H EPSDG Family Plan	Leave blank. Not required by Medicare.	
Item 24I EMG	Leave blank. Not required by Medicare.	
Item 24J COB	**If the performing provider of service/supplier is a member of a group practice**, enter the first two digits of the National Provider Identifier (NPI).	The NPI system was adopted as of January 22, 2004. The final rule establishing the NPI as the standard unique health identifier will be effective as of May 23, 2005.
Item 24K Reserved for Local Use	**If the performing provider of service/supplier is a member of a group practice**, enter the remaining six digits of the National Provider Identifier (NPI), including the two-digit location identifier.	When several different providers of service or suppliers within a group are billing on the same form, show the individual NPI in the corresponding line item. The NPI system was adopted as of January 22, 2004. The final rule establishing the NPI as the standard unique health identifier will be effective as of May 23, 2005.
Item 25 Federal Tax ID Number	Enter the provider of service or supplier Federal Tax ID Number (Employer Identification Number) or Social Security Number (SSN). The participating provider of service or supplier Federal Tax ID Number is required for a mandated Medigap transfer.	
Item 26 Patient's Account Number	**OPTIONAL:** Enter the patient's account number assigned by the provider of service's or supplier's accounting system to assist in patient identification.	

Item	Information To Be Entered	Notes
Provider of Service or Supplier Information (Con't)		
Item 27 Accept Assignment?	Check the appropriate item to indicate that the provider of service/supplier accepts assignment of Medicare benefits. If Medigap is indicated in Item 9 and Medigap payment authorization is given in Item 13, the provider of service/supplier must also be a Medicare participant and must accept assignment of Medicare benefits for all charges for all patients.	The following providers of service/suppliers can only be paid on an assignment basis: ❖ Clinical diagnostic laboratory services; ❖ Physician services to individuals dually entitled to Medicare and Medicaid; ❖ Participating physician/supplier services; ❖ Services of physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives, certified registered nurse anesthetists, clinical psychologists, and clinical social workers; ❖ Ambulatory surgical center (ASC) services for ASC procedures; ❖ Home dialysis supplies and equipment paid under Method II. ❖ Ambulance services; and ❖ Drugs and biologicals.
Item 28 Total Charge	Enter the total charges for the services (i.e., total of all charges in Item 24F).	
Item 29 Amount Paid	Enter the total amount the patient paid on covered services only.	
Item 30 Balance Due	Leave blank. Not required by Medicare.	
Item 31 Signature of Physician or Supplier Including Degrees or Credentials	Enter the signature of the provider of service or supplier, or his or her representative, and either the six-digit (MM|DD|YY), eight-digit (MM|DD|YYYY), or alphanumeric (e.g., January 1, 2003) date the form was signed.	
Item 32 Name and Address of Facility Where Services Were Rendered	**If services were provided in a hospital, clinic, laboratory, or facility other than the patient's home or physician's office**, enter the name and address of the facility.	Providers of service (namely physicians) must identify the supplier's name, address, and NPI when billing for purchased diagnostic tests.

Item	Information To Be Entered	Notes
Provider of Service or Supplier Information (Con't)		
Item 32 (con't) Name and Address of Facility Where Services Were Rendered	**If the name and address where services were provided are the same as the biller's name and address shown in Item 33**, enter "SAME". **If a QB or QU modifier is billed to indicate that the service was rendered in a Health Professional Shortage Area (HPSA)**, enter the physical location where the service was rendered if other than at the patient's home. **If the address shown in Item 33 is in a HPSA and is the same location as where services were rendered**, enter "SAME". **If the supplier is a certified mammography screening center**, enter their six-digit Food and Drug Administration (FDA)-approved certification number.	When more than one supplier is used, a separate Form CMS-1500 should be used to bill for each supplier. This item is completed whether the supplier personnel performs the work at the physician's office or at another location. A QB modifier is used for services provided in a rural HPSA. A QU modifier is used for services provided in an urban HPSA.
Item 33 Physician's, Supplier's Billing Name, Address, ZIP Code, & Phone #	Enter the provider of service/supplier's billing name, address, ZIP Code, and telephone number. **If the performing provider of service/supplier is <u>NOT</u> a member of a group practice**, enter the National Provider Identifier (NPI), including the two-digit location identifier. **If the performing provider of service/supplier <u>IS</u> a member of a group practice**, enter the group NPI, including the two-digit location identifier.	The NPI system was adopted as of January 22, 2004. The final rule establishing the NPI as the standard unique health identifier will be effective as of May 23, 2005.

REFERENCE C: FORM CMS-1500 - ELECTRONIC CLAIM FORMAT ITEM CROSSWALK

This crosswalk specifies both conditional and required standard data elements that serve as the minimal requirements for processing a Part B claim. This crosswalk relates Form CMS-1500 items (hardcopy) to the electronic National Standard Format (NSF) and 837 format fields/records. Updates to this crosswalk are located within Chapter 26, Completing and Processing Form CMS-1500, of the *Medicare Claims Processing Manual* which is available at http://www.cms.hhs.gov/manuals/104_claims/ on the Web.

This crosswalk does not specify field/record content or size. For this information, refer to the printing specifications that are included as part of the instructions for completing the Form CMS-1500, available at http://www.cms.hhs.gov/providers/edi/edi5.asp on the Web.

Key	
R	Required field - must always be on the claim.
C	Conditional field - required on a claim if certain conditions exist.
NR	Not required field - either optional or is not required to process a claim.
**	Required field prior to mandated use of Plan ID. Not used after Plan ID is mandated.
Shaded Field	Shaded fields within the following table indicates a field where common Part B provider billing errors often occur, as described in Table 5-1 of this guide.

Note: Claims will be returned as unprocessable if the information in the following crosswalk is incomplete or invalid.

Data Element Requirements Matrix					
CMS 1500	**NSF 3.01**	**American National Standards Institute (ANSI) 837 Version 4010**	**Paper Item Description**	**Electronic Data Interchange (EDI) Data Element Description**	**Medicare Status (Required or Conditional for EDI)***
1A	DA0 - 18.0	Loop 2010BA 2-015-NM109	Insured I.D. Number	Subscriber Primary Identifier	R
2	CA0 - 04.0	Loop 2010BA 2-015-NM103	Patient Name	Subscriber Last Name	R
	CA0 - 05.0	Loop 2010BA 2-015-NM104		Subscriber First Name	R
4	DA0 - 19.0	Loop 2330A 2-325-NM103	Insured Name	Other Insured Last Name	C
	DA0 - 20.0	Loop 2330A 2-325-NM104		Other Insured First Name	C

Data Element Requirements Matrix					
CMS 1500	**NSF 3.01**	**ANSI 837 Version 4010**	**Paper Item Description**	**EDI Data Element Description**	**Medicare Status (Required or Conditional for EDI)***
6	DA0 - 17.0	Loop 2000B 2-005-SBR02	Patient Relationship to Insured	Individual Relationship Code	C
		Loop 2320 2-290-SBR02			
7	DA2 - 04.0	Loop 2330A 2-332-N301	Insured's Address	Other Insured Address Line 1	C
	DA2 - 06.0	Loop 2330A 2-340-N401		Other Insured City	C
	DA2 - 07.0	Loop 2330A 2-340-N402		Other Insured State	C
	DA2 - 08.0	Loop 2330A 2-340-N403		Other Insured ZIP Code	C
	DA2 - 09.0	Not Used	Insured Telephone Number		NR
8	CA0 - 17.0	Not Used	Patient Status		NR
	CA0 - 18.0	Not Used	Patient Student Status		NR
	CA0 - 19.0	Not Used	Patient Employment Status		NR
11	DA0 - 10.0	Loop 2320 2-290-SBR03	Insured's Policy Group Number	Insure Group or Policy Number	C
	DA0 - 05.0	Loop 2320 2-290-SBR09		Claim Filing Indicator Code	C**
	DA0 - 06.0	Loop 2320 2-290-SBR05		Insurance Type Code	C
11C	DA0 - 11.0	Loop 2320 2-290-SBR04	Insurance Plan or Program Name	Other Insured Group Name	C

Data Element Requirements Matrix					
CMS 1500	**NSF 3.01**	**ANSI 837 Version 4010**	**Paper Item Description**	**EDI Data Element Description**	**Medicare Status (Required or Conditional for EDI)***
12	DA0 - 16.0	Loop 2300 2-130-CLM10	Patient Signature Source	Patient Signature Source Code	C
	EA0 - 13.0	Loop 2300 2-130-CLM09		Release of Information Indicator	R
14	EA0 - 07.0	Loop 2300 2-135-DTP03(439)	Date of Current Illness, etc.	Accident Date	C
	GC0 - 05.0	Loop 2300 2-135-DTP03(454) OR Loop 2400 2-455-DTP03(454)		Initial Treatment Date	C
15	EA0 - 15.0	Not Used	Patient Has Same/ Similar Illness	Same/Similar Symptom Indicator	NR
	EA0 - 16.0	Loop 2300 2-135-DTP03(438) OR Loop 2400 2-455-DTP03(438) Loop 2300 2-135-DTP03(431) OR Loop 2400 2-455-DTP03(431)	Date of Current Illness or Injury	Onset of Similar Symptoms or Illness Onset of Current Illness or Injury	C C
17	EA0 - 24.0 EA0 - 25.0	Loop 2310A 2-250-NM103 OR Loop 2420F 2-500-NM103 Loop 2310A 2-250-NM104 OR Loop 2420F 2-500-NM104	Name of Referring Provider	Referring Provider Last Name Referring Provider First Name	C C
			OR		
	FB1 - 06.0	Loop 2420E 2-500-NM103		Ordering Provider Last Name	C
	FB1 - 07.0	Loop 2420E 2-500-NM104		Ordering Provider First Name	C
			OR		

Data Element Requirements Matrix					
CMS 1500	**NSF 3.01**	**ANSI 837 Version 4010**	**Paper Item Description**	**EDI Data Element Description**	**Medicare Status (Required or Conditional for EDI)***
17A	FB1 - 09.0	Loop 2420E 2-525-REF02(1G)	I.D. Number of Referring Physician	Ordering Provider Secondary Identifier Unique Physician Identification Number (UPIN)	C
			OR		
	FB0 - 09.0	Loop 2420E 2-500-NM109(24 or 34)		Order Provider Primary Identifier Social Security Number (SSN) or IRS Employer Tax ID (EIN)	C
			OR		
	EA0 - 20.0	Loop 2310A 2-250-NM109(24 or 34) OR Loop 2420F 2-500-NM109(24 or 34)		Referring Provider Primary Identifier (SSN or EIN)	C
			OR		
	EA0 - 21.0 FB1 - 13.0	Loop 2310A 2-271-REF02(1G) OR Loop 2420F 2-525-REF02(1G)		Referring Provider Secondary Identifier (UPIN)	C
19	EA1 - 16.0	Loop 2310E 2-250-NM109 OR Loop 2420D 2-500-NM109	Reserved for Local Use	Supervising Provider Primary Identifier (UPIN)	C
	FB1 - 21.0	Loop 2310E 2-271-REF02(1G) OR Loop 2420D-2-525-REF02(1G)		Supervising Provider Secondary Identifier Provider Identification Number (PIN)	C
	GC0 - 06.0 EA0 - 48.0	Loop 2300 2-135-DTP03(455) OR Loop 2400 2-455-DTP03(455) Loop 2300 2-135-DTP03(304) OR Loop 2400 2-455-DTP03(304)		X-ray Date Last Seen	C
	EA0 - 50.0	Loop 2300 2-220-CRC03(IH)		Homebound Indicator	C

Data Element Requirements Matrix					
CMS 1500	**NSF 3.01**	**ANSI 837 Version 4010**	**Paper Item Description**	**EDI Data Element Description**	**Medicare Status (Required or Conditional for EDI)***
19 (con't)	EA1 - 25.0 FA0 - 40.0	Loop 2300 2-135 DTP03(090/091) Loop 2400 2-450-CRC02(70)		Assumed and Relinquished Care Dates Hospice Employed Provider Indicator	C
20	FB0 - 05.0	Loop 2400 2-488-PS102	Outside Laboratory	Purchased Service Charge	C
21	EA0 - 32.0	Loop 2300 2-231-HI01-02(BK)	Diagnosis	Principal Diagnosis Code	C
	EA0 - 33.0	Loop 2300 2-231-HI02-02(BF)		Diagnosis Code	C
	EA0 - 34.0	Loop 2300 2-231-HI03-02(BF)		Diagnosis Code	C
	EA0 - 35.0	Loop 2300 2-231-HI04-02(BF)		Diagnosis Code	C
22			Medicaid Resubmission Code		NR
	BA0 - 18.0	Loop 2010AA or 2010AB 2-015-NM103(85,2)		Payer Organization Name	R
	BA1 - 13.0	Loop 2010AA or 2010AB 2-025-N301		Pay-To Provider Address 1	R
	BA1 - 15.0	Loop 2010AA or 2010AB 2-030-N401		Pay-To Provider City Name	R
	BA1 - 16.0	Loop 2010AA or 2010AB 2-030-N402		Pay-To Provider State Code	R
	BA1 - 17.0	Loop 2010AA or 2010AB 2-030-N403		Pay-To Provider ZIP Code	R
	BA1 - 18.0	Loop 2010AA 2-040-PER04		Communication Number	C
			OR		
	BA0 - 09.0 BA0 - 02.0	Loop 2010AA or 2010AB 2-015-NM109(24 or 34)	Provider's Billing Name & Address	Billing Provider Primary Identifier (SSN or EIN)	R
	CA0 - 28.0	Loop 2010AA or 2010AB 2-035-REF02(1C)		Billing Provider Secondary Identifier (PIN)	C

REFERENCE D: BENEFICIARY ADMISSION QUESTIONNAIRE

The following questionnaire contains questions that the provider should ask Medicare beneficiaries upon each inpatient and outpatient admission. Providers can use this questionnaire to help identify other payers that may be primary to Medicare. Beginning with Part 1, providers should ask the patient each question in sequence and comply with any follow-up instructions that pertain to an answer provided by the beneficiary. If the instructions direct the provider to proceed to another part of the questionnaire, the provider should have the patient answer, in sequence, each question within that subsequent section of the questionnaire.

Part I:

1. Are you receiving Black Lung Benefits?

   ☐ Yes; Date benefits began: _____ (in YYYY|MM|DD format)

   IF YES, BLACK LUNG BENEFIT IS PRIMARY PAYER ONLY FOR CLAIMS RELATED TO BLACK LUNG.

   ☐ No

2. Are the services to be paid by a government program such as a research grant?

   ☐ Yes

   IF YES, A GOVERNMENT PROGRAM WILL PAY PRIMARY BENEFITS FOR THESE SERVICES.

   ☐ No

3. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for care at this facility?

   ☐ Yes

   IF YES, THE DVA IS PRIMARY PAYER FOR THESE SERVICES.

   ☐ No

4. Was the illness/injury due to a work-related accident/condition?

   ☐ Yes; Date of injury/illness _____ (in YYYY|MM|DD format)

   Name and address of Workers' Compensation (WC) Plan:
   _____
   _____
   _____
   _____

Policy or Identification Number _____

Name and address of the employer

_____
_____
_____
_____

IF YES, WC IS PRIMARY PAYER ONLY FOR CLAIMS RELATED TO WORK-RELATED INJURIES OR ILLNESS. PROCEED TO PART III.

☐ No

IF NO, PROCEED TO PART II.

Part II:

1. Was illness/injury due to a non-work related accident?

☐ Yes; Date of accident _____ (in YYYY|MM|DD format)

☐ No

IF NO, PROCEED TO PART III.

2. What type of accident caused the illness/injury?

☐ Automobile

☐ Non-automobile

Name and address of no-fault or liability insurer

_____
_____
_____
_____

Insurance Claim Number _____

NO-FAULT INSURER IS PRIMARY PAYER ONLY FOR THOSE CLAIMS RELATED TO THE ACCIDENT. PROCEED TO PART III.

☐ Other

3. Was another party responsible for this accident?

☐ Yes;

Name and address of any liability insurer

_____
_____
_____
_____

Insurance claim number _____

LIABILITY INSURER IS PRIMARY PAYER ONLY FOR THOSE CLAIMS RELATED TO THE ACCIDENT. PROCEED TO PART III.

☐ No

PROCEED TO PART III.

Part III:

1. Are you entitled to Medicare based on:

☐ Age

PROCEED TO PART IV.

☐ Disability

PROCEED TO PART V.

☐ ESRD

PROCEED TO PART VI.

Part IV - Age:

1. Are you currently employed?

☐ Yes

Name and address of your employer:

_____
_____
_____
_____

☐ No; Date of retirement _____ (in YYYY|MM|DD format)

2. Is your spouse currently employed?

☐ Yes

Name and address of spouse's employer:

_____
_____
_____
_____

☐ No; Date of retirement: _____ (in YYYY|MM|DD format)

IF THE PATIENT ANSWERED NO TO BOTH QUESTIONS 1 AND 2 ABOVE, MEDICARE IS PRIMARY PAYER. IF THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR II, MEDICARE IS NOT PRIMARY PAYER. DO NOT PROCEED FURTHER.

3. Do you have Group Health Plan (GHP) coverage based on your own, or a spouse's current employment?

☐ Yes

☐ No

IF NO, STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO THE QUESTIONS IN PART I OR II.

4. Does the employer that sponsors your Group Health Plan (GHP) employ 20 or more employees?

☐ Yes

IF YES, STOP. GHP IS PRIMARY PAYER. OBTAIN THE FOLLOWING INFORMATION:

Name and address of GHP:

_____
_____
_____
_____

Policy identification number: _____

Group identification number: _____

Name of policyholder: _____

Relationship to patient: _____

☐ No

IF NO, STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR II.

Part V - Disability:

1. Are you currently employed?

   ☐ Yes

   Name and address of your employer:

   _____
   _____
   _____
   _____

   ☐ No; Date of retirement: _____ (in YYYY|MM|DD format)

2. Is a family member currently employed?

   ☐ Yes

   Name and address of your employer:

   _____
   _____
   _____
   _____

   ☐ No

   IF THE PATIENT ANSWERED NO TO BOTH QUESTIONS 1 AND 2 ABOVE, MEDICARE IS PRIMARY PAYER, UNLESS THE PATIENT ANSWERED YES TO BOTH QUESTIONS 1 AND 2 IN PARTS I AND II. DO NOT PROCEED FURTHER.

3. Do you have Group Health Plan (GHP) coverage based on your own, or a family member's, current employment?

   ☐ Yes

   ☐ No

   IF NO, STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO THE QUESTIONS IN PART I OR II.

4. Does the employer that sponsors your Group Health Plan (GHP) employ 100 or more employees?

   ☐ Yes

   IF YES, STOP. GHP IS PRIMARY PAYER. OBTAIN THE FOLLOWING INFORMATION:

Name and address of GHP:

_____
_____
_____
_____

Policy identification number: _____

Group identification number: _____

Name of policyholder: _____

Relationship to patient: _____

☐ No

IF NO, STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR II.

Part VI - ESRD:

1. Do you have Group Health Plan (GHP) coverage?

☐ Yes

Name and address of GHP:

_____
_____
_____
_____

Policy Identification Number: _____

Group Identification Number: _____

Name of policyholder: _____

Relationship to patient: _____

Name and address of employer, if any, from which you receive GHP coverage:

_____
_____
_____
_____

☐ No

IF NO, STOP. MEDICARE IS PRIMARY PAYER.

2. Have you received a kidney transplant?

   ☐ Yes; Date of transplant: _____ (in YYYY|MM|DD format)

   ☐ No

3. Have you received maintenance dialysis treatments?

   ☐ Yes; Date dialysis began: _____ (in YYYY|MM|DD format)

   If you participated in a self-dialysis training program, provide date training started: _____ (in YYYY|MM|DD format)

   ☐ No

4. Are you within the 30-month coordination period?

   ☐ Yes

   ☐ No

   IF NO, STOP. MEDICARE IS PRIMARY PAYER.

5. Are you entitled to Medicare on the basis of either end-stage renal disease (ESRD) and age or ESRD and disability?

   ☐ Yes

   ☐ No

   IF NO, STOP. GROUP HEALTH PLAN (GHP) IS PRIMARY PAYER DURING THE 30-MONTH COORDINATION PERIOD.

6. Are you entitled to Medicare on the basis of either end-stage renal disease and age (ESRD) or ESRD and disability?

   ☐ Yes

   IF YES, STOP. GROUP HEALTH PLAN (GHP) CONTINUES TO BE PRIMARY PAYER DURING THE 30-MONTH COORDINATION PERIOD.

   ☐ No

   INITIAL ENTITLEMENT IS BASED ON AGE OR DISABILITY.

7. Does the working aged or disability Medicare Secondary Payer (MSP) provision apply (i.e., is the Group Health Plan (GHP) primarily based on age or disability entitlement)?

☐ Yes

IF YES, STOP. GHP CONTINUES AS PRIMARY PAYER DURING THE 30-MONTH COORDINATION PERIOD.

☐ No

IF NO, MEDICARE CONTINUES AS PRIMARY PAYER.

If no MSP data are found in the Common Working File (CWF) for the beneficiary, the provider still asks the questions and provides any MSP information on the bill using the proper uniform billing codes. This information will then be used to update the CWF through the billing process.

REFERENCE E: PLACE OF SERVICE (POS) CODES

Please note that all information listed below was accurate per the Centers for Medicare & Medicaid Services (CMS) website at the time of printing; however, this information is subject to change.

POS CODE SET

This reference contains the POS code set accepted by Medicare and instructions for using it. An asterisk (*) flags new codes. CMS updates this code set on a quarterly basis, as necessary. For additional information, refer to Chapter 26, Completing and Processing Form CMS-1500 Data Set, of the *Medicare Claims Processing Manual* that is located at http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp on the Web.

The Form CMS-1500 POS codes, definitions, and an indication whether the services in a given setting are to be paid at the facility or non-facility rate are listed below. A short list with POS codes and short definitions is listed first, followed by a list containing a full definition of the POS.

POS CODES AND SHORT DEFINITIONS

CODES	DEFINITION	CODES	DEFINITION
00-02	Unassigned	35-40	Unassigned
03	School	41	Ambulance - Land
04	Homeless Shelter	42	Ambulance - Air or Water
05	Indian Health Service Free-Standing Facility	43-48	Unassigned
06	Indian Health Service Provider-Based Facility	49	Independent Clinic
07	Tribal 638 Provider-Based Facility	50	Federally Qualified Health Center
08	Tribal 638 Provider-Based Facility	51	Inpatient Psychiatric Facility
09-10	Unassigned	52	Psychiatric Facility Partial Hospitalization
11	Office	53	Community Mental Health Center
12	Home	54	Intermediate Care Facility/Mentally Retarded
13	Assisted Living Facility	55	Residential Substance Abuse Treatment Facility
14	Group Home	56	Psychiatric Residential Treatment
15	Mobile Unit	57	Non-residential Substance Abuse Treatment Facility
16-19	Unassigned	58-59	Unassigned
20	Urgent Care Facility	60	Mass Immunization Center
21	Inpatient Hospital	61	Comprehensive Inpatient Rehabilitation Center
22	Outpatient Hospital	62	Comprehensive Outpatient Rehabilitation Center

CODES	DEFINITION	CODES	DEFINITION
23	Emergency Room Hospital	63-64	Unassigned
24	Ambulatory Surgical Center	65	End-Stage Renal Disease Treatment Facility
25	Birthing Center	66-70	Unassigned
26	Military Treatment Facility	71	State or Local Health Clinic
27-30	Unassigned	72	Rural Health Clinic
31	Skilled Nursing Facility	73-80	Unassigned
32	Nursing Facility	81	Independent Laboratory
33	Custodial Care Facility	82-98	Unassigned
34	Hospice	99	Other Place of Service

POS CODES AND FULL DESCRIPTIONS

POS Code/Name Description* = New code/code not previously implemented by Medicare	**Payment Rate** Facility = F Non-facility = NF
01-02 = Unassigned	
03 - School A facility whose primary purpose is education.	NF
04* - Homeless Shelter A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters). (See note below.)	NF
05* - Indian Health Service Free-Standing Facility A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization. (See note below.)	Not applicable for adjudication of Medicare claims; systems must recognize for HIPAA.
06* - Indian Health Service Provider-Based Facility A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients. (See note below.)	Not applicable for adjudication of Medicare claims; systems must recognize for HIPAA.
07* - Tribal 638 Free-Standing Facility A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members who do not require hospitalization. (See note below.)	Not applicable for adjudication of Medicare claims; systems must recognize for HIPAA.

POS Code/Name Description* = New code/code not previously implemented by Medicare	Payment Rate Facility = F Non-facility = NF
08* - Tribal 638 Provider-Based Facility A facility or location owned and operated by a federally recognizedAmerican Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members admitted as inpatients or outpatients. (See note below.)	Not applicable for adjudication of Medicare claims; systems must recognize for HIPAA.
09-10 = Unassigned	
11 - Office Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.	NF
12 - Home Location, other than a hospital or other facility, where the patient receives care in a private residence.	NF
13* - Assisted Living Facility Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, seven days a week, with the capacity to deliver or arrange for services including some health care and other services.	NF
14* - Group Home Congregate residential foster care setting for children and adolescents in state custody that provides some social, healthcare, and educational support services and that promotes rehabilitation and reintegration of residents into the community.	NF
15* - Mobile Unit A facility/unit that moves from place to place equipped to provide preventive, screening, diagnostic, and/or treatment services.	NF
16-19 = Unassigned	
20 - Urgent Care Facility Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.	NF
21 - Inpatient Hospital A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.	F

POS Code/Name Description* = New code/code not previously implemented by Medicare	Payment Rate Facility = F Non-facility = NF
22 - Outpatient Hospital A portion of a hospital that provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.	F
23 - Emergency Room - Hospital A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided	F
24 - Ambulatory Surgical Center A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.	Pay at the non-facility rate for payable procedures not on the ASC list.
25 - Birthing Center A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate post-partum care as well as immediate care of newborn infants.	NF
26 - Military Treatment Facility A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTFs).	F
27-30 = Unassigned	
31 - Skilled Nursing Facility A facility that primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.	F
32 - Nursing Facility A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.	NF
33 - Custodial Care Facility A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.	NF
34 - Hospice A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.	F
35-40 = Unassigned	

POS Code/Name Description* = New code/code not previously implemented by Medicare	Payment Rate Facility = F Non-facility = NF
41 - Ambulance - Land A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.	F
42 - Ambulance - Air or Water An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.	F
43-48 = Unassigned	
49* - Independent Clinic A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only.	NF
50 - Federally Qualified Health Center A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.	F
51 - Inpatient Psychiatric Facility A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.	F
52 - Psychiatric Facility-Partial Hospitalization A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full-time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.	F
53 - Community Mental Health Center A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to state mental health facilities to determine the appropriateness of such admission; and consultation and education services.	F
54 - Intermediate Care Facility/Mentally Retarded A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or SNF.	NF

POS Code/Name Description* = New code/code not previously implemented by Medicare	Payment Rate Facility = F Non-facility = NF
55 - Residential Substance Abuse Treatment Facility A facility that provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.	NF
56 - Psychiatric Residential Treatment Center A facility or distinct part of a facility for psychiatric care that provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.	F
57* - Non-residential Substance Abuse Treatment Facility A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing.	NF
58-59 - Unassigned	
60 - Mass Immunization Center A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.	NF
61 - Comprehensive Inpatient Rehabilitation Facility A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, orthotics, and prosthetics services.	F
62 - Comprehensive Outpatient Rehabilitation Facility A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.	NF
63-64 = Unassigned	
65 - End-Stage Renal Disease Treatment Facility A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.	NF
66-70 = Unassigned	

POS Code/Name Description* = New code/code not previously implemented by Medicare	Payment Rate Facility = F Non-facility = NF
71 - State or Local Public Health Clinic A facility maintained by either State or local health departments that provide ambulatory primary medical care under the general direction of a physician.	NF
72 - Rural Health Clinic A certified facility that is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.	NF
73-80 = Unassigned	
81 - Independent Laboratory A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.	NF
82-98 = Unassigned	
99 - Other Place of Service Other place of service not identified above.	NF

REFERENCE F: HEALTH CARE CLAIM ADJUSTMENT REASON CODES

(Last Updated 9/2003)

Please note that all information listed below was accurate per the Centers for Medicare & Medicaid Services (CMS) website at the time of printing; however, this information is subject to change.

Health Care Claim Adjustment Reason Codes are used to explain any adjustment in payment. This code list is updated quarterly as necessary, and can be downloaded at http://www.wpc-edi.com/Codes/Codes.asp on the Web.

Code	Description	Notes
1	Deductible Amount.	
2	Coinsurance Amount.	
3	Co-payment Amount.	
4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	
5	The procedure code/bill type is inconsistent with the Place of Service (POS).	
6	The procedure/revenue code is inconsistent with the patient's age.	Changed as of 6/02
7	The procedure/revenue code is inconsistent with the patient's gender.	Changed as of 6/02
8	The procedure code is inconsistent with the provider type/specialty (taxonomy).	Changed as of 6/02
9	The diagnosis is inconsistent with the patient's age.	
10	The diagnosis is inconsistent with the patient's gender.	Changed as of 2/00
11	The diagnosis is inconsistent with the procedure.	
12	The diagnosis is inconsistent with the provider type.	
13	The date of death precedes the date of service.	
14	The date of birth follows the date of service.	
15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	Changed as of 2/01
16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using Remittance Advice remarks codes whenever appropriate.	Changed as of 2/02
17	Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using the Remittance Advice remarks codes whenever appropriate.	Changed as of 2/02

Code	Description	Notes
18	Duplicate claim/service.	
19	Claim denied because this is a work-related injury/illness and thus the liability of the Workers' Compensation carrier.	
20	Claim denied because this injury/illness is covered by the liability carrier.	
21	Claim denied because this injury/illness is the liability of the no-fault carrier.	
22	Payment adjusted because this care may be covered by another payer per Coordination of Benefits (COB).	Changed as of 2/01
23	Payment adjusted because charges have been paid by another payer.	Changed as of 2/01
24	Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.	Changed as of 6/00
25	Payment denied. Your stop loss deductible has not been met.	
26	Expenses incurred prior to coverage.	
27	Expenses incurred after coverage terminated.	
28	Coverage not in effect at the time the service was provided.	Inactive for 004010, since 6/98. Redundant to Codes 26 and 27.
29	The time limit for filing has expired.	
30	Payment adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.	Changed as of 2/01
31	Claim denied as patient cannot be identified as our insured.	
32	Our records indicate that this dependent is not an eligible dependent as defined.	
33	Claim denied. Insured has no dependent coverage.	
34	Claim denied. Insured has no coverage for newborns.	
35	Lifetime benefit maximum has been reached.	Changed as of 10/02
36	Balance does not exceed co-payment amount.	Inactive for 003040
37	Balance does not exceed deductible.	Inactive for 003040
38	Services not provided or authorized by designated (network/primary care) providers.	Changed as of 6/03
39	Services denied at the time authorization/pre-certification was requested.	
40	Charges do not meet qualifications for emergent/urgent care.	
41	Discount agreed to in Preferred Provider contract.	Inactive for 003040
42	Charges exceed our fee schedule or maximum allowable amount.	
43	Gramm-Rudman reduction.	
44	Prompt-pay discount.	
45	Charges exceed your contracted/ legislated fee arrangement.	
46	This (these) service(s) is (are) not covered.	Inactive for 004010, since 6/00. Use Code 96.

Code	Description	Notes
47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.	Changed as of 6/00
48	This (these) procedure(s) is (are) not covered.	Inactive for 004010, since 6/00. Use Code 96.
49	These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam.	
50	These are non-covered services because this is not deemed a 'medical necessity' by the payer.	
51	These are non-covered services because this is a pre-existing condition.	
52	The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service.	Changed as of 10/98
53	Services by an immediate relative or a member of the same household are not covered.	
54	Multiple physicians/assistants are not covered in this case.	
55	Claim/service denied because procedure/treatment is deemed experimental/investigational by the payer.	
56	Claim/service denied because procedure/treatment has not been deemed 'proven to be effective' by the payer.	
57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.	Inactive for 004050. Split into Codes 150, 151, 152, 153 and 154.
58	Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.	Changed as of 2/01
59	Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules.	Changed as of 6/00
60	Charges for outpatient services with this proximity to inpatient services are not covered.	
61	Charges adjusted as penalty for failure to obtain second surgical opinion.	Changed as of 6/00
62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.	Changed as of 2/01
63	Correction to a prior claim.	Inactive for 003040
64	Denial reversed per Medical Review.	Inactive for 003040
65	Procedure Code was incorrect. This payment reflects the correct code.	Inactive for 003040
66	Blood Deductible.	
67	Lifetime reserve days. (Handled in QTY, QTY01=LA)	Inactive for 003040
68	DRG weight. (Handled in CLP12)	Inactive for 003040
69	Day outlier amount.	
70	Cost outlier - Adjustment to compensate for additional costs.	Changed as of 6/01

Code	Description	Notes
71	Primary Payer amount.	Deleted as of 6/00. Use Code 23.
72	Coinsurance day. (Handled in QTY, QTY01=CD)	Inactive for 003040
73	Administrative days.	Inactive for 003050
74	Indirect Medical Education Adjustment.	
75	Direct Medical Education Adjustment.	
76	Disproportionate Share Adjustment.	
77	Covered days. (Handled in QTY, QTY01=CA)	Inactive for 003040
78	Non-Covered days/Room charge adjustment.	
79	Cost Report days. (Handled in MIA15)	Inactive for 003050
80	Outlier days. (Handled in QTY, QTY01=OU)	Inactive for 003050
81	Discharges.	Inactive for 003040
82	PIP days.	Inactive for 003040
83	Total visits.	Inactive for 003040
84	Capital Adjustment (Handled in MIA).	Inactive for 003050
85	Interest amount.	
86	Statutory Adjustment.	Inactive for 004010, since 6/98. Duplicative of Code 45.
87	Transfer amount.	
88	Adjustment amount represents collection against receivable created in prior overpayment.	Inactive for 004050
89	Professional fees removed from charges.	
90	Ingredient cost adjustment.	
91	Dispensing fee adjustment.	
92	Claim Paid in full.	Inactive for 003040
93	No Claim level Adjustments.	Inactive for 004010, since 2/99. In 004010, CAS at the claim level is optional.
94	Processed in excess of charges.	
95	Benefits adjusted. Plan procedures not followed.	Changed as of 6/00
96	Non-covered charge(s).	
97	Payment is included in the allowance for another service/procedure.	Changed as of 2/99
98	The hospital must file the Medicare claim for this inpatient non-physician service.	Inactive for 003040
99	Medicare Secondary Payer Adjustment Amount.	Inactive for 003040
100	Payment made to patient/insured/responsible party.	
101	Predetermination: anticipated payment upon completion of services or claim adjudication.	Changed as of 2/99

Code	Description	Notes
102	Major Medical Adjustment.	
103	Provider promotional discount (e.g., senior citizen discount).	Changed as of 6/01
104	Managed care withholding.	
105	Tax withholding.	
106	Patient payment option/election not in effect.	
107	Claim/service denied because the related or qualifying claim/service was not paid or identified on this claim.	Changed as of 6/03
108	Payment adjusted because rent/purchase guidelines were not met.	Changed as of 6/02
109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.	
110	Billing date predates service date.	
111	Not covered unless the provider accepts assignment.	
112	Payment adjusted as not furnished directly to the patient and/or not documented.	Changed as of 2/01
113	Payment denied because service/procedure was provided outside the United States or as a result of war.	Changed as of 2/01
114	Procedure/product not approved by the Food and Drug Administration.	
115	Payment adjusted as procedure postponed or canceled.	Changed as of 2/01
116	Payment denied. The advance indemnification notice signed by the patient did not comply with requirements.	Changed as of 2/01
117	Payment adjusted because transportation is only covered to the closest facility that can provide the necessary care.	Changed as of 2/01
118	Charges reduced for ESRD network support.	
119	Benefit maximum for this time period has been reached.	
120	Patient is covered by a managed care plan.	Inactive for 004030, since 6/99. Use Code 24.
121	Indemnification adjustment.	
122	Psychiatric reduction.	
123	Payer refund due to overpayment.	Inactive for 004030, since 6/99. Refer to implementation guide for proper handling of reversals.
124	Payer refund amount - not our patient.	Inactive for 004030, since 6/99. Refer to implementation guide for proper handling of reversals.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the Remittance Advice remarks codes whenever appropriate.	Changed as of 2/02

Code	Description	Notes
126	Deductible - Major Medical.	New as of 2/97
127	Coinsurance - Major Medical.	New as of 2/97
128	Newborn's services are covered in the mother's Allowance.	New as of 2/97
129	Payment denied - Prior processing information appears incorrect.	Changed as of 2/01
130	Claim submission fee.	Changed as of 6/01
131	Claim specific negotiated discount.	New as of 2/97
132	Prearranged demonstration project adjustment.	New as of 2/97
133	The disposition of this claim/service is pending further review.	Changed as of 10/99
134	Technical fees removed from charges.	New as of 10/98
135	Claim denied. Interim bills cannot be processed.	New as of 10/98
136	Claim Adjusted. Plan procedures of a prior payer were not followed.	Changed as of 6/00
137	Payment/Reduction for Regulatory Surcharges, Assessments, Allowances or Health Related Taxes.	New as of 2/99
138	Claim/service denied. Appeal procedures not followed or time limits not met.	New as of 6/99
139	Contracted funding agreement - Subscriber is employed by the provider of services.	New as of 6/99
140	Patient/Insured health identification number and name do not match.	New as of 6/99
141	Claim adjustment because the claim spans eligible and ineligible periods of coverage.	Changed as of 6/00
142	Claim adjusted by the monthly Medicaid patient liability amount.	New as of 6/00
143	Portion of payment deferred.	New as of 2/01
144	Incentive adjustment (e.g., preferred product/service).	New as of 6/01
145	Premium payment withholding.	New as of 6/02
146	Payment denied because the diagnosis was invalid for the date(s) of service reported.	New as of 6/02
147	Provider contracted/negotiated rate expired or not on file.	New as of 6/02
148	Claim/service rejected at this time because information from another provider was not provided or was insufficient/incomplete.	New as of 6/02
149	Lifetime benefit maximum has been reached for this service/benefit category.	New as of 10/02
150	Payment adjusted because the payer deems the information submitted does not support this level of service.	New as of 10/02
151	Payment adjusted because the payer deems the information submitted does not support this many services.	New as of 10/02
152	Payment adjusted because the payer deems the information submitted does not support this length of service.	New as of 10/02
153	Payment adjusted because the payer deems the information submitted does not support this dosage.	New as of 10/02

Code	Description	Notes
154	Payment adjusted because the payer deems the information submitted does not support this day's supply.	New as of 10/02
155	This claim is denied because the patient refused the service/procedure.	New as of 6/03
156	Flexible spending account payments.	New as of 6/03
157	Payment denied/reduced because service/procedure was provided as an act of war.	New as of 9/03
158	Payment denied/reduced because service/procedure was provided outside of the U.S.	New as of 9/03
159	Payment denied/reduced because service/procedure was provided as a result of tourism.	New as of 9/03
160	Payment denied/reduced because service/procedure was provided as a result of an activity that is a benefit exclusion.	New as of 9/03
A0	Patient refund amount.	
A1	Claim denied charges.	
A2	Contractual adjustment.	
A3	Medicare Secondary Payer liability met.	Inactive for 004010, since 6/98.
A4	Medicare Claim PPS Capital Day Outlier Amount.	
A5	Medicare Claim PPS Capital Cost Outlier Amount.	
A6	Prior hospitalization or 30-day transfer requirement not met.	
A7	Presumptive Payment Adjustment.	
A8	Claim denied; ungroupable DRG.	
B1	Non-covered visits.	
B2	Covered visits.	Inactive for 003040
B3	Covered charges.	Inactive for 003040
B4	Late filing penalty.	
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.	Changed as of 2/01
B6	This payment is adjusted when performed/billed by this type of provider, by this type of provider in this type of facility, or by a provider of this specialty.	Changed as of 2/01
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	Changed as of 10/98
B8	Claim/service not covered/reduced because alternative services were available, and should have been utilized.	
B9	Services not covered because the patient is enrolled in a Hospice.	
B10	Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.	
B11	The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.	

Code	Description	Notes
B12	Services not documented in patients' medical records.	
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	
B14	Payment denied because only one visit or consultation per physician per day is covered.	Changed as of 2/01
B15	Payment adjusted because this procedure/service is not paid separately.	Changed as of 2/01
B16	Payment adjusted because 'New Patient' qualifications were not met.	Changed as of 2/01
B17	Payment adjusted because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current.	Changed as of 2/01
B18	Payment denied because this procedure Code/modifier was invalid on the date of service or claim submission.	Changed as of 2/01
B19	Claim/service adjusted because of the finding of a Review Organization.	Inactive for 003070
B20	Payment adjusted because procedure/service was partially or fully furnished by another provider.	Changed as of 2/01
B21	The charges were reduced because the service/care was partially furnished by another physician.	Inactive for 003040
B22	This payment is adjusted based on the diagnosis.	Changed as of 2/01
B23	Payment denied because this provider has failed an aspect of a proficiency testing program.	Changed as of 2/01
D1	Claim/service denied. Level of subluxation is missing or inadequate.	Inactive for 004010, since 2/99. Use Code 16 and Remark Codes if necessary.
D2	Claim lacks the name, strength, or dosage of the drug furnished.	Inactive for 004010, since 2/99. Use Code 16 and Remark Codes if necessary.
D3	Claim/service denied because information to indicate if the patient owns the equipment that requires the part or supply was missing.	Inactive for 004010, since 2/99. Use Code 16 and Remark Codes if necessary.
D4	Claim/service does not indicate the period of time for which this will be needed.	Inactive for 004010, since 2/99. Use Code 16 and Remark Codes if necessary.
D5	Claim/service denied. Claim lacks individual Laboratory Codes included in the test.	Inactive for 004010, since 2/99. Use Code 16 and Remark Codes if necessary.

Code	Description	Notes
D6	Claim/service denied. Claim did not include patient's medical record for the service.	Inactive for 004010, since 2/99. Use Code 16 and Remark Codes if necessary.
D7	Claim/service denied. Claim lacks date of patient's most recent physician visit.	Inactive for 004010, since 2/99. Use Code 16 and Remark Codes if necessary.
D8	Claim/service denied. Claim lacks indicator that 'x-ray is available for review'.	Inactive for 004010, since 2/99. Use Code 16 and Remark Codes if necessary.
D9	Claim/service denied. Claim lacks invoice or statement certifying the actual cost of the lens, less discounts or the type of intraocular lens used.	Inactive for 004010, since 2/99. Use Code 16 and Remark Codes if necessary.
D10	Claim/service denied. Completed physician financial relationship form not on file.	Inactive for 003070, since 8/97. Use Code 17.
D11	Claim lacks completed pacemaker registration form.	Inactive for 003070, since 8/97. Use Code 17.
D12	Claim/service denied. Claim does not identify who performed the purchased diagnostic test or the amount you were charged for the test.	Inactive for 003070, since 8/97. Use Code 17.
D13	Claim/service denied. Performed by a facility/supplier in which the ordering/referring physician has a financial interest.	Inactive for 003070, since 8/97. Use Code 17.
D14	Claim lacks indication that plan of treatment is on file.	Inactive for 003070, since 8/97. Use Code 17.
D15	Claim lacks indication that service was supervised or evaluated by a physician.	Inactive for 003070, since 8/97. Use Code 17.
W1	Workers' Compensation State Fee Schedule Adjustment.	New as of 2/00

REFERENCE G: REMITTANCE ADVICE (RA) REMARK CODES

(Last Updated 2/1/2004)

Please note that all information listed below was accurate per the Centers for Medicare & Medicaid Services (CMS) website at the time of printing; however, this information is subject to change.

The RA remark code list is updated three times per year. The most recent list can be access at http://www.wpc-edi.com/codes/Codes.asp on the Web.

GENERAL INFORMATION

Any remark code may now be reported at the service or the claim level, as applicable, in any electronic or paper remittance advice version.

Rather than renumber existing M (prior service level) and MA (prior claim level) codes, and possibly confuse providers, "old" code numbers have been retained. All new post-consolidation remark codes, however, will begin with an N. The "N" is used to quickly differentiate remark codes from claim adjustment reason codes. Remark codes that apply at the service level must be reported in the X12 835 LQ segment. Remark codes that apply to an entire claim must be reported in the X12 835 MIA (inpatient) or MOA (non-inpatient) segment, as applicable.

REMARK CODES

Note: For the purpose of using these codes, the terms "you" and "your" refer to the provider, and the terms "us" and "we" refer to Medicare.

A new or modified code is effective and can be used by a provider as soon as the revised list is published. A deactivation becomes effective six months after the scheduled publication date of the code list.

Code	Description	Notes
M1	X-ray not taken within the past 12 months or near enough to the start of treatment.	
M2	Not paid separately when the patient is an inpatient.	
M3	Equipment is the same or similar to equipment already being used.	
M4	This is the last monthly installment payment for this Durable Medical Equipment (DME).	
M5	Monthly rental payments can continue until the earlier of the 15th month from the first rental month, or the month when the equipment is no longer needed.	
M6	You must furnish and service this item for as long as the patient continues to need it. We can pay for maintenance and/or servicing for every 6 month period after the end of the 15th paid rental month or the end of the warranty period.	
M7	No rental payments after the item is purchased, or after the total of issued rental payments equals the purchase price.	

Code	Description	Notes
M8	We do not accept blood gas tests results when the test was conducted by a medical supplier or taken while the patient is on oxygen.	
M9	This is the tenth rental month. You must offer the patient the choice of changing the rental to a purchase agreement.	
M10	Equipment purchases are limited to the first or the tenth month of medical necessity.	
M11	DME, orthotics and prosthetics must be billed to the DME carrier who services the patient's ZIP Code.	
M12	Diagnostic tests performed by a physician must indicate whether purchased services are included on the claim.	
M13	No more than one initial visit may be covered per specialty per medical group. Visit may be rebilled with an established visit code.	Modified 6/30/03.
M14	No separate payment for an injection administered during an office visit, and no payment for a full office visit if the patient only received an injection.	
M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	
M16	Please see the letter or bulletin (date) for further information.	Deactivated effective 1/31/04.
M17	Payment approved as you did not know, and could not reasonably have been expected to know, that this would not normally have been covered for this patient. In the future, you will be liable for charges for the same service(s) under the same or similar conditions.	
M18	Certain services may be approved for home use. Neither a hospital nor a Skilled Nursing Facility (SNF) is considered to be a patient's home.	Modified 6/30/03.
M19	Missing/incomplete/invalid oxygen certification/re-certification.	Modified 2/28/03.
M20	Missing/incomplete/invalid HCPCS.	Modified 2/28/03.
M21	Missing/incomplete/invalid place of residence for this service/item provided in a home.	Modified 2/28/03.
M22	Missing/incomplete/invalid number of miles traveled.	Modified 2/28/03.
M23	Invoice needed for the cost of the material or contrast agent.	
M24	Missing/incomplete/invalid number of doses per vial.	Modified 2/28/03.

Code	Description	Notes
M25	Payment has been adjusted because the information furnished does not substantiate the need for this level of service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this (more extensive) service, or if you notified the patient in writing in advance that we would not pay for this (more extensive) service and he/she agreed in writing to pay, ask us to review the claim within 120 days of the date of this notice. If you do not request a review, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her (for the/in excess of any deductible and coinsurance amounts applicable to the less extensive) service. We will recover the reimbursement from you as an overpayment.	Modified 10/1/02, 6/30/03.
M26	Payment has been adjusted because the information furnished does not substantiate the need for this level of service. If you have collected any amount from the patient for this level of service /any amount that exceeds the limiting charge for the less extensive service, the law requires you to refund that amount to the patient within 30 days of receiving this notice. The law permits exceptions to the refund requirement in two cases: ❖ If you did not know, and could not have reasonably been expected to know, that we would not pay for this service; or ❖ If you notified the patient in writing before providing the service that you believed that we were likely to deny the service, and the patient signed a statement agreeing to pay for the service. If you come within either exception, or if you believe the carrier was wrong in its determination that we do not pay for this service, you should request review of this determination within 30 days of the date of this notice. Your request for review should include any additional information necessary to support your position. If you request review within 30 days of receiving this notice, you may delay refunding the amount to the patient until you receive the results of the review. If the review decision is favorable to you, you do not need to make any refund. If, however, the review is unfavorable, the law specifies that you must make the refund within 15 days of receiving the unfavorable review decision. The law also permits you to request review at any time within 120 days of the date of this notice. However, a review request that is received more than 30 days after the date of this notice, does not permit you to delay making the refund. Regardless of when a	Modified 10/1/02, 6/30/03.

Code	Description	Notes
M26 (con't)	review is requested, the patient will be notified that you have requested one, and will receive a copy of the determination. The patient has received a separate notice of this denial decision. The notice advises that he/she may be entitled to a refund of any amounts paid, if you should have known that we would not pay and did not tell him/her. It also instructs the patient to contact your office if he/she does not hear anything about a refund within 30 days. The requirements for refund are in 1842(l) of the Social Security Act and 42CFR411.408. The section specifies that physicians who knowingly and willfully fail to make appropriate refunds may be subject to civil monetary penalties and/or exclusion from the program. Please contact this office if you have any questions about this notice.	
M27	The patient has been relieved of liability of payment of these items and services under the limitation of liability provision of the law. You are ultimately liable for the patient's waived charges, including any charges for coinsurance, since the items or services were not reasonable and necessary or constituted custodial care, and you knew or could reasonably have been expected to know, that they were not covered. This determination may be appealed provided that the patient does not exercise his/her appeal rights. If the beneficiary appeals the initial determination, you are automatically made a party to the appeals determination. If, however, the patient or his/her representative has stated in writing that he/she does not intend to request a reconsideration, or the patient's liability was entirely waived in the initial determination, you may initiate an appeal. You may ask for a reconsideration for hospital insurance (or a review for medical insurance) regarding both the coverage determination and the issue of whether you exercised due care. The request for reconsideration must be filed within 120 days of the date of this notice (or, for a medical insurance review, within 120 days of the date of this notice). The request can be made through any Social Security office.	Modified 10/1/02.
M28	This does not qualify for payment under Part B when Part A coverage is exhausted or not otherwise available.	
M29	Missing/incomplete/invalid operative report.	Modified 2/28/03.
M30	Missing/incomplete/invalid pathology report.	Modified 2/28/03.
M31	Missing/incomplete/invalid radiology report.	Modified 2/28/03.

Code	Description	Notes
M32	This is a conditional payment made pending a decision on this service by the patient's primary payer. This payment may be subject to refund upon your receipt of any additional payment for this service from another payer. You must contact this office immediately upon receipt of an additional payment for this service.	
M33	Missing/incomplete/invalid UPIN for the ordering/referring/performing provider.	Modified 2/28/03. Deactivated effective 8/1/04. Use M68.
M34	Claim lacks the CLIA certification number.	Deactivated effective 8/1/04. Use MA120.
M35	Missing/incomplete/invalid pre-operative photos or visual field results.	Modified 2/28/03.
M36	This is the 11th rental month. We cannot pay for this until you indicate that the patient has been given the option of changing the rental to a purchase.	
M37	Service not covered when the patient is under age 35.	
M38	The patient is liable for the charges for this service as you informed the patient in writing before the service was furnished that we would not pay for it, and the patient agreed to pay.	
M39	The patient is not liable for payment for this service as the advance notice of noncoverage you provided the patient did not comply with program requirements.	Modified 2/1/04.
M40	Claim must be assigned and must be filed by the practitioner's employer.	
M41	We do not pay for this as the patient has no legal obligation to pay for this.	
M42	The medical necessity form must be personally signed by the attending physician.	
M43	Payment for this service previously issued to you or another provider by another carrier/Intermediary.	Deactivated effective 1/31/04. Use M23.
M44	Missing/incomplete/invalid condition code.	Modified 2/28/03.
M45	Missing/incomplete/invalid occurrence codes or dates.	Modified 2/28/03.
M46	Missing/incomplete/invalid occurrence span code or dates.	Modified 2/28/03.
M47	Missing/incomplete/invalid internal or document control number.	Modified 2/28/03.
M48	Payment for services furnished to hospital inpatients (other than professional services of physicians) can only be made to the hospital. You must request payment from the hospital rather than the patient for this service.	Deactivated effective 1/31/04. Use M97.
M49	Missing/incomplete/invalid value code(s) or amount(s).	Modified 2/28/03.
M50	Missing/incomplete/invalid revenue code(s).	Modified 2/28/03.
M51	Missing/incomplete/invalid procedure code(s) and/or rates.	Modified 2/28/03, 2/1/04.

Code	Description	Notes
M52	Missing/incomplete/invalid “from” date(s) of service.	Modified 2/28/03.
M53	Missing/incomplete/invalid days or units of service.	Modified 2/28/03.
M54	Missing/incomplete/invalid total charges.	Modified 2/28/03.
M55	Medicare does not pay for self-administered anti-emetic drugs that are not administered with a covered oral anti-cancer drug.	
M56	Missing/incomplete/invalid payer identifier.	Modified 2/28/03.
M57	Missing/incomplete/invalid provider identifier.	Modified 2/28/03.
M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.	Modified 2/28/03.
M59	Missing/incomplete/invalid “to” date(s) of service.	Modified 2/28/03.
M60	Missing/incomplete/invalid Certificate of Medical Necessity.	Modified 6/30/03.
M61	We cannot pay for this as the approval period for the FDA clinical trial has expired.	
M62	Missing/incomplete/invalid treatment authorization code.	Modified 2/28/03.
M63	We do not pay for more than one of these on the same day.	Deactivated effective 1/31/04. Use M86.
M64	Missing/incomplete/invalid other diagnosis.	Modified 2/28/03.
M65	One interpreting physician charge can be submitted per claim when a purchased diagnostic test is indicated. You should submit a separate claim for each interpreting physician.	
M66	Our records indicate that you billed diagnostic tests subject to price limitations and the procedure code submitted includes a professional component. Only the technical component is subject to price limitations. Please submit the technical and professional components of this service as separate line items.	
M67	Missing/incomplete/invalid other procedure code(s) and/or date(s).	Modified 2/28/03.
M68	Missing/incomplete/invalid attending, ordering, rendering, supervising or referring physician identification.	Modified 2/28/03, 2/1/04.
M69	Paid at the regular rate as you did not submit documentation to justify the modified procedure code.	Modified 2/1/04.
M70	NDC code submitted for this service was translated to an HCPCS code for processing, but please continue to submit the NDC on future claims for this item.	
M71	Total payment reduced due to overlap of tests billed.	
M72	Did not enter full 8-digit date (MM|DD|YYYY).	Deactivated effective 10/16/2003. Use MA52.
M73	The HPSA bonus can only be paid on the professional component of this service. Rebill as separate professional and technical components. Use the HPSA modifier on the professional component only.	
M74	This service does not qualify for a HPSA bonus payment.	
M75	Allowed amount adjusted. Multiple automated multichannel tests performed on the same day combined for payment.	

Code	Description	Notes
M76	Missing/incomplete/invalid diagnosis or condition.	Modified 2/28/03.
M77	Missing/incomplete/invalid place of service.	Modified 2/28/03.
M78	Missing/incomplete/invalid HCPCS modifier.	Modified 2/28/03.
M79	Missing/incomplete/invalid charge.	Modified 2/28/03.
M80	Not covered when performed during the same session/date as a previously processed service for the patient.	Modified 10/31/02.
M81	You are required to code to the highest level of specificity.	Modified 2/1/04.
M82	Service is not covered when patient is under age 50.	
M83	Service is not covered unless the patient is classified as at high risk.	
M84	Medical code sets used must be the codes in effect at the time of service.	Modified 2/1/04.
M85	Subjected to review of physician evaluation and management services.	
M86	Service denied because payment already made for same/similar procedure within set time frame.	Modified 6/30/03.
M87	Claim/service(s) subjected to CFO-CAP prepayment review.	
M88	We cannot pay for laboratory tests unless billed by the laboratory that did the work.	Deactivated effective 8/1/04. Use Reason Code B20.
M89	Not covered more than once under age 40.	
M90	Not covered more than once in a 12 month period.	
M91	Laboratory procedures with different CLIA certification numbers must be billed on separate claims.	
M92	Services subjected to review under the Home Health Medical Review Initiative.	Deactivated effective 8/1/04.
M93	Information supplied supports a break in therapy. A new capped rental period began with delivery of this equipment.	
M94	Information supplied does not support a break in therapy. A new capped rental period will not begin.	
M95	Services subjected to Home Health Initiative medical review/cost report audit.	
M96	The technical component of a service furnished to an inpatient may only be billed by that inpatient facility. You must contact the inpatient facility for technical component reimbursement. If not already billed, you should bill us for the professional component only.	
M97	Not paid to practitioner when provided to patient in this place of service. Payment included in the reimbursement issued the facility.	
M98	Begin to report the Universal Product Number on claims for items of this type. We will soon begin to deny payment for items of this type if billed without the correct UPN.	Deactivated effective 1/31/04. Use M99.

Code	Description	Notes
M99	Missing/incomplete/invalid Universal Product Number/Serial Number.	Modified 2/28/03.
M100	We do not pay for an oral anti-emetic drug that is not administered for use immediately before, at, or within 48 hours of administration of a covered chemotherapy drug.	
M101	Begin to report a G1-G5 modifier with this HCPCS. We will soon begin to deny payment for this service if billed without a G1-G5 modifier.	Deactivated effective 1/31/04. Use M78.
M102	Service not performed on equipment approved by the FDA for this purpose.	
M103	Information supplied supports a break in therapy. However, the medical information we have for this patient does not support the need for this item as billed. We have approved payment for this item at a reduced level, and a new capped rental period will begin with the delivery of this equipment.	
M104	Information supplied supports a break in therapy. A new capped rental period will begin with delivery of the equipment. This is the maximum approved under the fee schedule for this item or service.	
M105	Information supplied does not support a break in therapy. The medical information we have for this patient does not support the need for this item as billed. We have approved payment for this item at a reduced level, and a new capped rental period will not begin.	
M106	Information supplied does not support a break in therapy. A new capped rental period will not begin. This is the maximum approved under the fee schedule for this item or service.	Deactivated effective 1/31/2004. Use MA31.
M107	Payment reduced as 90-day rolling average hematocrit for ESRD patient exceeded 36.5%.	
M108	Missing/incomplete/invalid provider identifier for the provider who interpreted the diagnostic test.	Modified 2/28/03.
M109	We have provided you with a bundled payment for a teleconsultation. You must send 25% of the teleconsultation payment to the referring practitioner.	
M110	Missing/incomplete/invalid provider identifier for the provider from whom you purchased interpretation services.	Modified 2/28/03.
M111	We do not pay for chiropractic manipulative treatment when the patient refuses to have an X-ray taken.	
M112	The approved amount is based on the maximum allowance for this item under the DMEPOS Competitive Bidding Demonstration.	
M113	Our records indicate that this patient began using this service(s) prior to the current round of the DMEPOS Competitive Bidding Demonstration. Therefore, the approved amount is based on the allowance in effect prior to this round of bidding for this item.	

Code	Description	Notes
M114	This service was processed in accordance with rules and guidelines under the Competitive Bidding Demonstration Project. If you would like more information regarding this project, phone 1-888-289-0710.	
M115	This item is denied when provided to this patient by a non-demonstration supplier.	
M116	Paid under the Competitive Bidding Demonstration. Project is ending, and future services may not be paid under this project.	Modified 2/1/04.
M117	Not covered unless submitted via electronic claim.	Modified 6/30/03.
M118	Letter to follow containing further information.	
M119	Missing/incomplete/invalid National Drug Code (NDC).	Modified 2/28/03.
M120	Missing/incomplete/invalid provider identifier for the substituting physician who furnished the service(s) under a reciprocal billing or locum tenens arrangement.	Modified 2/28/03.
M121	We pay for this service only when performed with a covered cryosurgical ablation.	
M122	Missing/incomplete/invalid level of subluxation.	Modified 2/28/03.
M123	Missing/incomplete/invalid name, strength, or dosage of the drug furnished.	Modified 2/28/03.
M124	Missing/incomplete/invalid indication of whether the patient owns the equipment that requires the part or supply.	Modified 2/28/03.
M125	Missing/incomplete/invalid information on the period of time for which the service/supply/equipment will be needed.	Modified 2/28/03.
M126	Missing/incomplete/invalid individual lab codes included in the test.	Modified 2/28/03.
M127	Missing/incomplete/invalid patient medical record for this service.	Modified 2/28/03.
M128	Missing/incomplete/invalid date of the patient's last physician visit.	Modified 2/28/03.
M129	Missing/incomplete/invalid indicator of X-ray availability for review.	Modified 2/28/03, 6/30/03.
M130	Missing/incomplete/invalid invoice or statement certifying the actual cost of the lens, less discounts, and/or the type of intraocular lens used.	Modified 2/28/03.
M131	Missing/incomplete/invalid physician financial relationship form.	Modified 2/28/03.
M132	Missing/incomplete/invalid pacemaker registration form.	Modified 2/28/03.
M133	Claim did not identify who performed the purchased diagnostic test or the amount that was charged for the test.	
M134	Performed by a facility/supplier in which the provider has a financial interest.	Modified 6/30/03.
M135	Missing/incomplete/invalid plan of treatment.	Modified 2/28/03.
M136	Missing/incomplete/invalid indication that the service was supervised or evaluated by a physician.	Modified 2/28/03.
M137	Part B coinsurance under a demonstration project.	

Code	Description	Notes
M138	Patient identified as a demonstration participant but the patient was not enrolled in the demonstration at the time services were rendered. Coverage is limited to demonstration participants.	
M139	Denied services exceed the coverage limit for the demonstration.	
M140	Service not covered until after the patient's 50th birthday (i.e., no coverage prior to the day after the 50th birthday).	Deactivated effective 1/31/04. Use M82.
M141	Missing/incomplete/invalid physician certified plan of care.	Modified 2/28/03.
M142	Missing/incomplete/invalid American Diabetes Association Certificate of Recognition.	Modified 2/28/03.
M143	We have no record that you are licensed to dispensed drugs in the State where located.	
M144	Pre-/post-operative care payment is included in the allowance for the surgery/procedure.	
MA01	If you do not agree with what we approved for these services, you may appeal the decision. To make sure that we are fair to you, we require another individual that did not process you initial claim to conduct the review. However, in order to be eligible for a review, you must write to Medicare within 120 days of the date of this notice, unless you have a good reason for being late. An institutional provider (e.g., hospital, SNF, HHA or hospice) may appeal only if the claim involves a reasonable and necessary denial, a SNF recertified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, or a hospice care denial because the patient was not terminally ill, and either the patient or the provider is liable under Section 1879 of the Social Security Act, and the patient chooses not to appeal. If your carrier issues telephone review decisions, a professional provider should phone the carrier's office for a telephone review if the criteria for a telephone review are met.	Modified 10/31/02, 6/30/03.
MA02	If you do not agree with the approved amounts and $100 or more is in dispute (less deductible and coinsurance), you may ask for a hearing. You must request a hearing within six months of the date of this notice. To meet the $100, you may combine amounts on other claims that have been denied. This includes reopened reviews if you received a revised decision. You must appeal each claim on time. At the hearing, you may present any new evidence which could affect our decision. An institutional provider (e.g., hospital, SNF, HHA or a hospice) may appeal only if the claim involves a reasonable and necessary denial, a SNF non-certified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, or a hospice care denial	Modified 10/31/02, 6/30/03.

Code	Description	Notes
MA02 (con't)	because the patient was not terminally ill, and either the patient or the provider is liable under Section 1879 of the Social Security Act, and the patient chooses not to appeal.	
MA03	If you do not agree with the approved amounts and $100 or more is in dispute (less deductible and coinsurance), you may ask for a hearing. You must request a hearing within six months of the date of this notice. To meet the $100, you may combine amounts on other claims that have been denied. This includes reopened reviews if you have received a revised decision. You must appeal each claim on time. At the hearing, you may present any new evidence which could affect our decision. An institutional provider (e.g., hospital, SNF, HHA or a hospice) may appeal only if the claim involves a reasonable and necessary denial, a SNF noncertified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, or a hospice care denial because the patient was not terminally ill, and either the patient or the provider is liable under Section 1879 of the Social Security Act, and the patient chooses not to appeal.	
MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.	
MA05	Incorrect admission date patient status or type of bill entry on claim.	Deactivated effective 10/16/2003. Use MA30 or MA40 or MA43.
MA06	Missing/incomplete/invalid beginning and/or ending date(s).	Modified 2/28/03. Deactivated effective 8/1/04. Use MA31.
MA07	The claim information has also been forwarded to Medicaid for review.	
MA08	You should also submit this claim to the patient's other insurer for potential payment of supplemental benefits. We did not forward the claim information as the supplemental coverage is not with a Medigap plan, or you do not participate in Medicare.	
MA09	Claim submitted as unassigned but processed as assigned. You must agree to accept assignment for all claims.	
MA10	The patient's payment was in excess of the amount owed. You must refund the overpayment to the patient.	
MA11	Payment is being issued on a conditional basis. If no-fault insurance, liability insurance, Workers' Compensation, Department of Veterans Affairs, or a group health plan for employees and dependents also covers this claim, a refund may be due to Medicare. Please contact Medicare if the patient is covered by any of these sources.	Deactivated effective 1/31/04. Use M32.

Code	Description	Notes
MA12	You have not established that you have the right under the law to bill for services furnished by the person(s) that furnished this (these) service(s).	
MA13	You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.	
MA14	Patient is a member of an employer-sponsored prepaid health plan. Services from outside that health plan are not covered. However, as you were not previously notified of this, we are paying this time. In the future, we will not pay you for non-plan services.	
MA15	The claim has been separated to expedite handling. You will receive a separate notice for the other services reported.	
MA16	The patient is covered by the Black Lung Program. Send this claim to the Department of Labor, Federal Black Lung Program, P.O. Box 828, Lanham-Seabrook MD 20703.	
MA17	We are the primary payer and have paid at the primary rate. You must contact the patient's other insurer to refund any excess it may have paid due to its erroneous primary payment.	
MA18	The claim information is also being forwarded to the patient's supplemental insurer. Send any questions regarding supplemental benefits to them.	
MA19	Information was not sent to the Medigap insurer due to incorrect/invalid information you submitted concerning that insurer. Please verify your information and submit the secondary claim directly to that insurer.	
MA20	Skilled Nursing Facility (SNF) stay not covered when care is primarily related to the use of an urethral catheter for convenience or the control of incontinence.	Modified 6/30/03.
MA21	SSA records indicate mismatch with name and sex.	
MA22	Payment of less than $1.00 suppressed.	
MA23	Demand bill approved as result of medical review.	
MA24	Christian Science Sanitarium/Skilled Nursing Facility (SNF) bill in the same benefit period.	Modified 6/30/03.
MA25	A patient may not elect to change a hospice provider more than once in a benefit period.	
MA26	Our records indicate that you were previously informed of this rule.	
MA27	Missing/incomplete/invalid entitlement number or name shown on the claim.	Modified 2/28/03.
MA28	Receipt of this notice by a physician or supplier who did not accept assignment is for information only and does not make the physician or supplier a party to the determination. No additional rights to appeal this decision, above those rights already provided for by regulation/instruction, are conferred by receipt of this notice.	
MA29	Missing/incomplete/invalid provider name, city, state, or ZIP Code.	Modified 2/28/03.

Code	Description	Notes
MA30	Missing/incomplete/invalid type of bill.	Modified 2/28/03.
MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.	Modified 2/28/03.
MA32	Missing/incomplete/invalid number of covered days during the billing period.	Modified 2/28/03.
MA33	Missing/incomplete/invalid noncovered days during the billing period.	Modified 2/28/03.
MA34	Missing/incomplete/invalid number of coinsurance days during the billing period.	Modified 2/28/03.
MA35	Missing/incomplete/invalid number of lifetime reserve days.	Modified 2/28/03.
MA36	Missing/incomplete/invalid patient name.	Modified 2/28/03.
MA37	Missing/incomplete/invalid patient's address.	Modified 2/28/03.
MA38	Missing/incomplete/invalid birth date.	Modified 2/28/03.
MA39	Missing/incomplete/invalid gender.	Modified 2/28/03.
MA40	Missing/incomplete/invalid admission date.	Modified 2/28/03.
MA41	Missing/incomplete/invalid admission type.	Modified 2/28/03.
MA42	Missing/incomplete/invalid admission source.	Modified 2/28/03.
MA43	Missing/incomplete/invalid patient status.	Modified 2/28/03.
MA44	No appeal rights. Adjudicative decision based on law.	
MA45	As previously advised, a portion or all of your payment is being held in a special account.	
MA46	The new information was considered, however, additional payment cannot be issued. Please review the information listed for the explanation.	
MA47	Our records show you have opted out of Medicare, agreeing with the patient not to bill Medicare for services/tests/supplies furnished. As result, we cannot pay this claim. The patient is responsible for payment.	
MA48	Missing/incomplete/invalid name or address of responsible party or primary payer.	Modified 2/28/03.
MA49	Missing/incomplete/invalid six-digit provider identifier for home health agency or hospice for physician(s) performing care plan oversight services.	Modified 2/28/03. Deactivated effective 8/1/04. Use MA76.
MA50	Missing/incomplete/invalid Investigational Device Exemption number for FDA-approved clinical trial services.	Modified 2/28/03.
MA51	Missing/incomplete/invalid CLIA certification number for laboratory services billed by physician office laboratory.	Modified 2/28/03.
MA52	Missing/incomplete/invalid date.	Modified 2/28/03.
MA53	Missing/incomplete/invalid Competitive Bidding Demonstration Project identification.	Modified 2/1/04.
MA54	Physician certification or election consent for hospice care not received timely.	

Code	Description	Notes
MA55	Not covered as patient received medical healthcare services, automatically revoking his/her election to receive religious non-medical health care services.	
MA56	Our records show you have opted out of Medicare, agreeing with the patient not to bill Medicare for services/tests/supplies furnished. As result, we cannot pay this claim. The patient is responsible for payment, but under Federal law, you cannot charge the patient more than the limiting charge amount.	
MA57	Patient submitted written request to revoke his/her election for religious non-medical health care services.	
MA58	Missing/incomplete/invalid release of information indicator.	Modified 2/28/03.
MA59	The patient overpaid you for these services. You must issue the patient a refund within 30 days for the difference between his/her payment and the total amount shown as patient responsibility on this notice.	
MA60	Missing/incomplete/invalid patient relationship to insured.	Modified 2/28/03.
MA61	Missing/incomplete/invalid social security number or health insurance claim number.	Modified 2/28/03.
MA62	Telephone review decision.	
MA63	Missing/incomplete/invalid principal diagnosis.	Modified 2/28/03.
MA64	Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers.	
MA65	Missing/incomplete/invalid admitting diagnosis.	Modified 2/28/03.
MA66	Missing/incomplete/invalid principal procedure code or date.	Modified 2/28/03.
MA67	Correction to a prior claim.	
MA68	We did not crossover this claim because the secondary insurance information on the claim was incomplete. Please supply complete information or use the PLANID of the insurer to assure correct and timely routing of the claim.	
MA69	Missing/incomplete/invalid remarks.	Modified 2/28/03.
MA70	Missing/incomplete/invalid provider representative signature.	Modified 2/28/03.
MA71	Missing/incomplete/invalid provider representative signature date.	Modified 2/28/03.
MA72	The patient overpaid you for these assigned services. You must issue the patient a refund within 30 days for the difference between his/her payment to you and the total of the amount shown as patient responsibility and as paid to the patient on this notice.	
MA73	Informational remittance associated with a Medicare demonstration. No payment issued under fee-for-service Medicare as patient has elected managed care.	
MA74	This payment replaces an earlier payment for this claim that was either lost, damaged or returned.	
MA75	Missing/incomplete/invalid patient or authorized representative signature.	Modified 2/28/03.

Code	Description	Notes
MA76	Missing/incomplete/invalid provider identifier for home health agency or hospice when physician is performing care plan oversight services.	Modified 2/28/03, 2/1/04.
MA77	The patient overpaid you and you must issue the patient a refund within 30 days for the difference between the patient's payment less the total of our and other payer payments and the amount shown as patient responsibility on this notice.	
MA78	The patient overpaid you. You must issue the patient refund within 30 days for the difference between our allowed amount total and the amount paid by the patient.	Deactivated effective 1/31/04. Use MA59.
MA79	Billed in excess of interim rate.	
MA80	Informational notice. No payment issued for this claim with this notice. Payment issued to the hospital by its Intermediary for all services for this encounter under a demonstration project.	
MA81	Missing/incomplete/invalid provider/supplier signature.	Modified 2/28/03.
MA82	Missing/incomplete/invalid provider/supplier billing number/identifier or billing name, address, city, state, ZIP code, or phone number.	Modified 2/28/03.
MA83	Did not indicate whether Medicare is the primary or secondary payer. Refer to the instructions for Block 11 of Form CMS-1500 for assistance.	
MA84	Patient identified as participating in the National Emphysema Treatment Trial but Medicare records indicate that this patient is either not a participant, or has not yet been approved for this phase of the study. Contact Johns Hopkins University, the study coordinator, to resolve if there was a discrepancy.	
MA85	Medicare records indicate that a primary payer exists (other than Medicare); however, the provider did not complete or enter accurately the insurance plan/group/program name or identification number. Enter the PlanID when effective.	Deactivated effective 1/31/04. Use MA59.
MA86	Missing/incomplete/invalid group or policy number of the insured for the primary coverage.	Modified 2/28/03. Deactivated effective 8/1/04 Use MA92.
MA87	Missing/incomplete/invalid insured's name for the primary payer.	Modified 2/28/03. Deactivated effective 8/1/04. Use MA92.
MA88	Missing/incomplete/invalid insured's address and/or telephone number for the primary payer.	Modified 2/28/03.
MA89	Missing/incomplete/invalid patient's relationship to the insured for the primary payer.	Modified 2/28/03.
MA90	Missing/incomplete/invalid employment status code for the primary insured.	Modified 2/28/03.
MA91	This determination is the result of the appeal filed by the provider.	
MA92	Missing/incomplete/invalid primary insurance information.	Modified 2/28/03, 2/1/04.

Code	Description	Notes
MA93	Non-Periodic Interim Payment (PIP) claim.	Modified 6/30/03.
MA94	Did not enter the statement “Attending physician not hospice employee” on the claim to certify that the rendering physician is not an employee of the hospice. Refer to Block 19 on Form CMS-1500.	Deactivated effective 1/31/04. No field on 837.
MA95	De-activate and refer to M51.	Modified 2/28/03.
MA96	Claim rejected. Coded as a Medicare Managed Care Demonstration but patient is not enrolled in a Medicare managed care plan.	
MA97	Missing/incomplete/invalid Medicare Managed Care Demonstration contract number.	
MA98	Claim Rejected. Does not contain the correct Medicare Managed Care Demonstration contract number for this beneficiary.	Deactivated effective 10/16/2003. Use MA97.
MA99	Missing/incomplete/invalid Medigap information.	Modified 2/28/03.
MA100	Missing/incomplete/invalid date of current illness, injury or pregnancy.	Modified 2/28/03.
MA101	A SNF is responsible for payment of outside providers who furnish these services/supplies to residents.	
MA102	Missing/incomplete/invalid name or provider identifier for the rendering/referring/ordering/supervising provider.	Modified 2/28/03. Deactivated effective 8/1/04. Use M68.
MA103	Hemophilia Add On.	
MA104	Missing/incomplete/invalid date the patient was last seen or the provider identifier of the attending physician.	Deactivated effective 1/31/04. Use M128 or M57.
MA105	Missing/incomplete/invalid provider number for this place of service.	Modified 2/28/03.
MA106	PIP (Periodic Interim Payment) claim.	Modified 6/30/03.
MA107	Paper claim contains more than three separate data items in field 19.	
MA108	Paper claim contains more than one data item in field 23.	
MA109	Claim processed in accordance with ambulatory surgical guidelines.	
MA110	Missing/incomplete/invalid information on whether the diagnostic test(s) were performed by an outside entity or if no purchased tests are included on the claim.	Modified 2/28/03.
MA111	Missing/incomplete/invalid purchase price of the test(s) and/or the performing laboratory's name and address.	Modified 2/28/03.
MA112	Missing/incomplete/invalid group practice information.	Modified 2/28/03.

Code	Description	Notes
MA113	Incomplete/invalid taxpayer identification number (TIN) submitted by the provider per the Internal Revenue Service. The providers claims cannot be processed without the correct TIN, and the provider may not bill the patient pending correction of their TIN. There are no appeal rights for unprocessable claims, but the provider may resubmit this claim after notifying Medicare of their correct TIN.	
MA114	Missing/incomplete/invalid information on where the services were furnished.	Modified 2/28/03.
MA115	Missing/incomplete/invalid physical location (name and address, or PIN) where the service(s) were rendered in a Health Professional Shortage Area (HPSA).	Modified 2/28/03.
MA116	Did not complete the statement “Homebound” on the claim to validate whether laboratory services were performed at home or in an institution.	Deactivated effective 1/31/04. No field in 837 for this statement.
MA117	This claim has been assessed a $1.00 user fee.	
MA118	Coinsurance and/or deductible amounts apply to a claim for services or supplies furnished to a Medicare-eligible veteran through a facility of the Department of Veterans Affairs. No Medicare payment issued.	
MA119	Provider level adjustment for late claim filing applies to this claim.	
MA120	Missing/incomplete/invalid CLIA certification number.	Modified 2/28/03.
MA121	Missing/incomplete/invalid date the X-ray was performed.	Modified 2/28/03, 6/30/03, 2/1/04.
MA122	Missing/incomplete/invalid initial date actual treatment occurred.	Modified 2/28/03.
MA123	Your center was not selected to participate in this study, therefore, Medicare cannot pay for these services.	
MA124	Processed for IME only.	Deactivated effective 1/31/04. Use Reason Code 74.
MA125	Per legislation governing this program, payment constitutes payment in full.	
MA126	Pancreas transplant not covered unless kidney transplant performed.	New Code 10/12/01.
MA127	Reserved for future use.	
MA128	Missing/incomplete/invalid six-digit FDA-approved, identification number.	Modified 2/28/03.
MA129	This provider was not certified for this procedure on this date of service.	Deactivated effective 1/31/04. Refer to MA120 and Reason Code B7.
MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	

Code	Description	Notes
MA131	Physician already paid for services in conjunction with this demonstration claim. You must have the physician withdraw that claim and refund the payment before we can process the claim.	
MA132	Adjustment to the pre-demonstration rate.	
MA133	Claim overlaps inpatient stay. Rebill only those services rendered outside the inpatient stay.	
MA134	Missing/incomplete/invalid provider number of the facility where the patient resides.	
N1	You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.	Modified 2/28/03.
N2	This allowance has been made in accordance with the most appropriate course of treatment provision of the plan.	
N3	Missing/incomplete/invalid consent form.	Modified 2/28/03.
N4	Missing/incomplete/invalid prior insurance carrier EOB.	Modified 2/28/03.
N5	EOB received from previous payer. Claim not on file.	
N6	Under FEHB Law (U.S.C. 8904(b)), we cannot pay more for covered care than the amount Medicare would have allowed if the patient were enrolled in Medicare Part A and/or Medicare Part B.	Modified 2/28/03.
N7	Processing of this claim/service has included consideration under Major Medical provisions.	
N8	Crossover claim denied by previous payer and complete claim data not forwarded. Resubmit this claim to this payer to provide adequate data for adjudication.	
N9	Adjustment represents the estimated amount the primary payer may have paid.	
N10	Claim/service adjusted based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor.	Modified 10/31/02.
N11	Denial reversed because of medical review.	
N12	Policy provides coverage supplemental to Medicare. As member does not appear to be enrolled in Medicare Part B, the member is responsible for payment of the portion of the charge that would have been covered by Medicare.	
N13	Payment based on professional/technical component modifier(s).	
N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.	
N15	Services for a newborn must be billed separately.	
N16	Family/member Out-of-Pocket maximum has been met. Payment based on a higher percentage.	
N17	Per admission deductible.	Deactivated effective 8/1/04. Use Reason Code 1.

Code	Description	Notes
N18	Payment based on the Medicare allowed amount.	Deactivated effective 1/31/04. Refer to N14.
N19	Procedure code incidental to primary procedure.	
N20	Service not payable with other service rendered on the same date.	
N21	Range of dates separated onto single lines.	
N22	This procedure code was added/changed because it more accurately describes the services rendered.	Modified 10/31/02, 2/28/03.
N23	Patient liability may be affected due to coordination of benefits with other carriers and/or maximum benefit provisions.	Modified 8/13/01.
N24	Missing/incomplete/invalid Electronic Funds Transfer (EFT) banking information.	Modified 2/28/03.
N25	This company has been contracted by the provider's benefit plan to provide administrative claims payment services only. This company does not assume financial risk or obligation with respect to claims processed on behalf of your benefit plan.	
N26	Missing/incomplete/invalid itemized bill.	Modified 2/28/03.
N27	Missing/incomplete/invalid treatment number.	Modified 2/28/03.
N28	Consent form requirements not fulfilled.	
N29	Missing/incomplete/invalid documentation/orders/notes/ summary/report/invoice.	Modified 2/28/03.
N30	Patient ineligible for this service.	Modified 6/30/03.
N31	Missing/incomplete/invalid prescribing/referring/attending provider license number.	Modified 2/28/03.
N32	Claim must be submitted by the provider who rendered the service.	Modified 6/30/03.
N33	No record of health check prior to initiation of treatment.	
N34	Incorrect claim form for this service.	
N35	Program integrity/utilization review decision.	
N36	Claim must meet primary payer's processing requirements before Medicare can consider payment.	
N37	Missing/incomplete/invalid tooth number/letter.	Modified 2/28/03.
N38	Missing/incomplete/invalid place of service.	Modified 2/28/03.
N39	Procedure code is not compatible with tooth number/letter.	
N40	Missing/incomplete/invalid X-ray.	Modified 2/28/03, 6/30/03, 2/1/04.
N41	Authorization request denied.	Deactivated effective 10/16/2003. Refer to Reason Code 39.
N42	No record of mental health assessment.	
N43	Bed hold or leave days exceeded.	

Code	Description	Notes
N44	Payer's share of regulatory surcharges, assessments, allowances or health care-related taxes paid directly to the regulatory authority.	Deactivated effective 10/16/2003. Refer to Reason Code 137.
N45	Payment based on authorized amount.	
N46	Missing/incomplete/invalid admission hour.	
N47	Claim conflicts with another inpatient stay.	
N48	Claim information does not agree with information received from other insurance carrier.	
N49	Court ordered coverage information needs validation.	
N50	Missing/incomplete/invalid discharge information.	Modified 2/28/03.
N51	Electronic interchange agreement not on file for provider/submitter.	
N52	Patient not enrolled in the billing provider's managed care plan on the date of service.	
N53	Missing/incomplete/invalid point of pick-up address.	Modified 2/28/03.
N54	Claim information is inconsistent with pre-certified/authorized services.	
N55	Procedures for billing with group/referring/performing providers were not followed.	
N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	Modified 2/28/03.
N57	Missing/incomplete/invalid prescribing/dispensed date.	Modified 2/28/03.
N58	Missing/incomplete/invalid patient liability amount.	Modified 2/28/03.
N59	Provider should refer to their provider manual for additional program and provider information.	
N60	A valid NDC is required for payment of drug claims effective October 2002.	Deactivated effective 1/31/04. Refer to M119.
N61	Rebill services on separate claims.	
N62	Inpatient admission spans multiple rate periods. Resubmit separate claims.	
N63	Rebill services on separate claim lines.	
N64	The “from” and “to” dates must be different.	
N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	Modified 2/28/03.
N66	Missing/incomplete/invalid documentation.	Modified 2/28/03.
N67	Professional provider services not paid separately. Included in facility payment under a demonstration project. Apply to that facility for payment, or resubmit your claim if: the facility notifies you that the patient was excluded from this demonstration; or if you furnished these services in another location on the date of the patient's admission or discharge from a demonstration hospital. If services were furnished in a facility not involved in the demonstration on the same date the patient was discharged from or admitted to a demonstration facility, you must report the provider ID number for the non-demonstration facility on the new claim.	

Code	Description	Notes
N68	Prior payment being cancelled as we were subsequently notified this patient was covered by a demonstration project in this site of service. Professional services were included in the payment made to the facility. You must contact the facility for payment. Prior payment made to you by the patient or another insurer for this claim must be refunded to the payer within 30 days.	
N69	Prospective Payment System (PPS) code changed by claims processing system. Insufficient visits or therapies.	Modified 6/30/03.
N70	Home health consolidated billing and payment applies.	Modified 2/28/02.
N71	Your unassigned claim for a drug or biological, clinical diagnostic laboratory services or ambulance service was processed as an assigned claim. You are required by law to accept assignment for these types of claims.	Modified 2/21/02, 6/30/03.
N72	Prospective Payment System (PPS) code changed by medical reviewers. Not supported by clinical records.	Modified 6/30/03.
N73	A Skilled Nursing Facility (SNF) is responsible for payment of outside providers who furnish these services/supplies under arrangement to its residents.	Modified 7/24/01, 2/28/03. Deactivated effective 1/31/04. Refer to MA101 and N200.
N74	Resubmit with multiple claims, each claim covering services provided in only one calendar month.	
N75	Missing/incomplete/invalid tooth surface information.	Modified 2/28/03.
N76	Missing/incomplete/invalid number of riders.	Modified 2/28/03.
N77	Missing/incomplete/invalid designated provider number.	Modified 2/28/03.
N78	The necessary components of the child and teen checkup (EPSDT) were not completed.	
N79	Service billed is not compatible with patient location information.	
N80	Missing/incomplete/invalid prenatal screening information.	Modified 2/28/03.
N81	Procedure billed is not compatible with tooth surface code.	
N82	Provider must accept insurance payment as payment in full when a third party payer contract specifies full reimbursement.	
N83	No appeal rights. Adjudicative decision based on the provisions of a demonstration project.	
N84	Further installment payments forthcoming.	
N85	Final installment payment.	
N86	A failed trial of pelvic muscle exercise training is required in order for biofeedback training for the treatment of urinary incontinence to be covered.	
N87	Home use of biofeedback therapy is not covered.	
N88	This payment is being made conditionally. An HHA episode of care notice has been filed for this patient. When a patient is treated under a HHA episode of care, consolidated billing requires that certain therapy services and supplies, such as this, be included in the HHA's payment. This payment will need to be recouped from you if we establish that the patient is concurrently receiving treatment under a HHA episode of care.	

Code	Description	Notes
N89	Payment information for this claim has been forwarded to more than one other payer, but format limitations permit only one of the secondary payers to be identified in this remittance advice.	
N90	Covered only when performed by the attending physician.	
N91	Services not included in the appeal review.	
N92	This facility is not certified for digital mammography.	
N93	A separate claim must be submitted for each place of service. Services furnished at multiple sites may not be billed in the same claim.	
N94	Claim/Service denied because a more specific taxonomy code is required for adjudication.	
N95	This provider type/provider specialty may not bill this service.	New code 7/31/01, Modified 2/28/03.
N96	Patient must be refractory to conventional therapy (documented behavioral, pharmacologic and/or surgical corrective therapy) and be an appropriate surgical candidate such that implantation with anesthesia can occur.	New code 8/24/01.
N97	Patients with stress incontinence, urinary obstruction, and specific neurologic diseases (e.g., diabetes with peripheral nerve involvement) which are associated with secondary manifestations of the above three indications are excluded.	New code 8/24/01.
N98	Patient must have had a successful test stimulation in order to support subsequent implantation. Before a patient is eligible for permanent implantation, he/she must demonstrate a 50% or greater improvement through test stimulation. Improvement is measured through voiding diaries.	New code 8/24/01.
N99	Patient must be able to demonstrate adequate ability to record voiding diary data such that clinical results of the implant procedure can be properly evaluated.	New code 8/24/01.
N100	Prospective Payment System (PPS) code corrected during adjudication.	New code 9/14/01. Modified 6/30/03.
N101	Additional information is needed in order to process this claim. Please resubmit the claim with the identification number of the provider where this service took place. The Medicare number of the site of service provider should be preceded with the letters “HSP” and entered into item #32 on the claim form. You may bill only one site of service provider number per claim.	New code 10/16/01. Deactivated effective 1/31/04. Refer to MA105.
N102	This claim has been denied without reviewing the medical record because the requested records were not received or were not received timely.	New code 10/31/01.
N103	Social Security records indicate that this beneficiary was a prisoner when the service was rendered. This payer does not cover items and services furnished to beneficiaries while they are in state or local custody under a penal authority, unless under state or local law, the beneficiary is personally liable for the cost of his or her	New code 12/05/01. Modified 4/8/02, 2/28/03, 6/30/03.

Code	Description	Notes
N103 (con't)	health care while incarcerated and the state or local government pursues such debt in the same way and with the same vigor as any other debt.	
N104	This claim/service is not payable under the our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS website at http://www.cms.hhs.gov.	New code 1/29/02, Modified 10/31/02.
N105	This is a misdirected claim/service for an 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.	New code 1/29/02.
N106	Payment for services furnished to SNF inpatients (except for excluded services) can only be made to the SNF. You must request payment from the SNF rather than the patient for this service.	New code 1/31/02.
N107	Services furnished to Skilled Nursing Facility (SNF) inpatients must be billed on the inpatient claim. They cannot be billed separately as outpatient services.	New code 1/31/02.
N108	Missing/incomplete/invalid upgrade information.	Modified 2/28/03.
N109	This claim was chosen for complex review and was denied after reviewing the medical records.	New Code 2/26/02.
N110	This facility is not certified for film mammography.	New Code 2/28/02.
N111	No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.	New Code 2/28/02.
N112	This claim is excluded from your electronic remittance advice.	New Code 2/28/02.
N113	Only one initial visit is covered per physician, group practice, or provider.	New Code 4/16/02. Modified 6/30/03.
N114	During the transition to the Ambulance Fee Schedule, payment is based on the lesser of a blended amount calculated using a percentage of the reasonable charge/cost and fee schedule amounts, or the submitted charge for the service. You will be notified yearly what the percentages for the blended payment calculation will be.	New Code 5/30/02.
N115	This decision was based on a local medical review policy (LMRP). An LMRP provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at www.cms.hhs.gov/mcd, or if you do not have Web access, you may contact the contractor to request a copy of the LMRP.	New Code 6/26/02. Modified 9/16/02, 6/30/03.
N116	This payment is being made conditionally because the service was provided in the home, and it is possible that the patient is under a home health episode of care. When a patient is treated under a home health episode of care, consolidated billing requires that certain therapy services and supplies, such as this, be included in the home health agency's (HHA's) payment. This payment will	New Code 6/30/02.

Code	Description	Notes
N116 (con't)	need to be recouped from you if we establish that the patient is concurrently receiving treatment under an HHA episode of care.	
N117	This service is paid only once in a patient's lifetime.	New Code 7/30/02. Modified 6/30/03.
N118	This service is not paid if billed more than once every 28 days.	New Code 7/30/02
N119	This service is not paid if billed once every 28 days, and the patient has spent five or more consecutive days in any inpatient or Skilled Nursing Facility (SNF) within those 28 days.	New Code 7/30/02. Modified 6/30/03.
N120	Payment is subject to home health prospective payment system partial episode payment adjustment. Patient was transferred/discharged/readmitted during payment episode.	New Code 8/9/02. Modified 6/30/03.
N121	No coverage or items or services provided by this type of practitioner for patients in a Skilled Nursing Facility (SNF) stay.	New Code 9/9/02. Modified 6/30/03.
N122	Mammography add-on code cannot be billed by itself.	New Code 9/12/02.
N123	This is a split service and represents a portion of the units from the originally submitted service.	New Code 9/24/02.
N124	Payment has been denied for the/made only for a less extensive service/item because the information furnished does not substantiate the need for the (more extensive) service/item. The patient is liable for the charges for this service/item as you informed the patient in writing before the service/item was furnished that we would not pay for it, and the patient agreed to pay.	New Code 9/26/02.
N125	Payment has been (denied for the/made only for a less extensive) service/item because the information furnished does not substantiate the need for the (more extensive) service/item. If you have collected any amount from the patient, you must refund that amount to the patient within 30 days of receiving this notice. The law permits refund requirement exceptions in two cases: ❖ If you did not know, and could not have reasonably been expected to know, that Medicare would not pay for this service/item; or ❖ If you notified the beneficiary in writing before providing it that Medicare likely would deny the service/item, and the beneficiary signed a statement agreeing to pay. If an exception applies to you or you believe the carrier was wrong in denying payment, you should request review of this determination by the carrier within 30 days of receiving this notice. Your request for review should include any additional information necessary to support your position. If you request review within 30 days, you may delay refunding to the beneficiary until you have received the results of the review. If the review determination is favorable to you then you do not have to make any refund. If the	New Code 9/26/02.

Code	Description	Notes
N125 (con't)	review is unfavorable, you must make the refund within 15 days of receiving the unfavorable review decision. You may request review of the determination at any time within 120 days of receiving this notice. A review requested after the 30-day period does not permit you to delay making the refund. Regardless of when a review is requested, the patient will be notified that you have requested one, and will receive a copy of the determination. The patient has received a separate notice of this denial decision. The notice advises that he or she may be entitled to a refund of any amounts paid, if you should have known that Medicare would not pay and did not tell him or her. It also instructs the patient to contact your office if he or she does not hear anything about a refund within 30 days. The requirements for refund are in §1834(a)(18) of the Social Security Act (and in §§1834(j)(4) and 1879(h) by cross-reference to §1834(a)(18)). Section 1834(a)(18)(B) specifies that suppliers which knowingly and willfully fail to make appropriate refunds may be subject to civil money penalties and/or exclusion from the Medicare Program. If you have any questions about this notice, please contact Medicare.	
N126	Social Security Records indicate that this individual has been deported. This payer does not cover items and services furnished to individuals who have been deported.	New Code 10/17/02.
N127	This is a misdirected claim/service for a United Mine Workers of America beneficiary. Submit paper claims to: UMWA Health and Retirement Funds, PO Box 389, Ephraim, UT 84627-0361. Call Envoy at 1-800-215-4730 for information on electronic claims submission.	New Code 10/31/02.
N128	This amount represents the prior to coverage portion of the allowance.	New Code 10/31/02.
N129	This amount represents the dollar amount not eligible due to the patient's age.	New Code 10/31/02.
N130	Consult plan benefit documents for information about restrictions for this service.	New Code 10/31/02.
N131	Total payments under multiple contracts cannot exceed the allowance for this service.	New Code 10/31/02.
N132	Payments will cease for services rendered by this U.S. Government-debarred or excluded provider after the 30 day grace period as previously notified.	New Code 10/31/02.
N133	Services for predetermination and services requesting payment are being processed separately.	New Code 10/31/02.

Code	Description	Notes
N134	This represents the provider's scheduled payment for this service. If treatment has been discontinued, please contact Customer Service.	New Code 10/31/02.
N135	Record fees are the patient's responsibility and limited to the specified co-payment.	New Code 10/31/02.
N136	To obtain information on the process to file an appeal in Arizona, call the Department's Consumer Assistance Office at (602) 912-8444 or (800) 325-2548.	New Code 10/31/02.
N137	You, the provider, acting on the Member's behalf, may file an appeal with Medicare. You, the provider, acting on the Member's behalf, may file a complaint with the Commissioner in the State of Maryland without first filing an appeal, if the coverage decision involves an urgent condition for which care has not been rendered. The Commissioner's address: Commissioner Steven B. Larsen, Maryland Insurance Administration, 525 St. Paul Place, Baltimore, MD 21202 - (410) 468-2000.	New Code 10/31/02. Modified 2/28/03.
N138	In the event you disagree with the Dental Advisor's opinion and have additional information relative to the case, you may submit radiographs to the Dental Advisor Unit at the subscriber's dental insurance carrier for a second Independent Dental Advisor Review.	New Code 10/31/02
N139	Under the Code of Federal Regulations, Chapter 32, Section 199.13, a non-participating provider is not an appropriate appealing party. Therefore, if you disagree with the Dental Advisor's opinion, you may appeal the determination if appointed in writing, by the beneficiary, to act as his/her representative. Should you be appointed as a representative, submit a copy of this letter, a signed statement explaining the matter in which you disagree, and any radiographs and relevant information to the subscriber's Dental insurance carrier within 90 days from the date of this letter.	New Code 10/31/02.
N140	You have not been designated as an authorized OCONUS provider, therefore are not considered an appropriate appealing party. If the beneficiary has appointed you, in writing, to act as his/her representative and you disagree with the Dental Advisor's opinion, you may appeal by submitting a copy of this letter, a signed statement explaining the matter in which you disagree, and any relevant information to the subscriber's Dental insurance carrier within 90 days from the date of this letter.	New Code 10/31/02.
N141	The patient was not residing in a long-term care facility during all or part of the service dates billed.	New Code 10/31/02.
N142	The original claim was denied. Resubmit a new claim, not a replacement claim.	New Code 10/31/02.
N143	The patient was not in a hospice program during all or part of the service dates billed.	New Code 10/31/02.
N144	The rate changed during the dates of service billed.	New Code 10/31/02.

Code	Description	Notes
N145	Missing/incomplete/invalid provider identifier for this place of service.	New Code 10/31/02.
N146	Missing/incomplete/invalid/not approved screening document.	New Code 10/31/02.
N147	Long term care case mix or per diem rate cannot be determined because the patient ID number is missing, incomplete, or invalid on the assignment request.	New Code 10/31/02.
N148	Missing/incomplete/invalid date of last menstrual period.	New Code 10/31/02.
N149	Rebill all applicable services on a single claim.	New Code 10/31/02.
N150	Missing/incomplete/invalid model number.	New Code 10/31/02.
N151	Telephone contact services will not be paid until the face-to-face contact requirement has been met.	New Code 10/31/02.
N152	Missing/incomplete/invalid replacement claim information.	New Code 10/31/02.
N153	Missing/incomplete/invalid room and board rate.	New Code 10/31/02.
N154	This payment was delayed for correction of provider's mailing address.	New Code 10/31/02.
N155	Our records do not indicate that other insurance is on file. Please submit other insurance information for our records.	New Code 10/31/02.
N156	The patient is responsible for the difference between the approved treatment and the elective treatment.	New Code 10/31/02.
N157	Transportation to and from this destination is not covered.	New Code 2/28/03.
N158	Transportation in a vehicle other than an ambulance is not covered.	New Code 2/28/03.
N159	Payment denied/reduced because mileage is not covered when the patient is not in the ambulance.	New Code 2/28/03.
N160	The beneficiary/patient must choose an option before this procedure/equipment/supply/service can be covered.	New Code 2/28/03.
N161	This drug/service/supply is covered only when the associated service is covered.	New Code 2/28/03.
N162	This is an alert. Although your claim was paid, you have billed for a test/specialty not included in your Laboratory Certification. Your failure to correct the Laboratory Certification information will result in a denial of payment in the near future.	New Code 2/28/03.
N163	Medical record does not support code billed per the code definition.	New Code 2/28/03.
N164	Transportation to/from this destination is not covered.	Deactivated effective 1/31/04. Refer to N157.
N165	Transportation in a vehicle other than an ambulance is not covered.	Deactivated effective 1/31/04. Refer to N158.
N166	Payment denied/reduced because mileage is not covered when the patient is not in the ambulance.	Deactivated effective 1/31/04. Refer to N159.
N167	Charges exceed the post-transplant coverage limit.	New Code 2/28/03

Code	Description	Notes
N168	The beneficiary must choose an option before a payment can be made for this procedure/equipment/supply/service.	Deactivated effective 1/31/04. Refer to N160.
N169	This drug/service/supply is covered only when the associated service is covered.	Deactivated effective 1/31/04. Refer to N161.
N170	A new/revised/renewed certificate of medical necessity is needed.	New Code 2/28/03.
N171	Payment for repair or replacement is not covered or has exceeded the purchase price.	New Code 2/28/03.
N172	The patient is not liable for the denied/adjusted charge(s) for receiving any updated service/item.	New Code 2/28/03.
N173	No qualifying hospital stay dates were provided for this episode of care.	New Code 2/28/03.
N174	This is not a covered service/procedure/ equipment/bed, however patient liability is limited to amounts shown in the adjustments under group “PR”.	New Code 2/28/03.
N175	Missing/incomplete/invalid Review Organization Approval.	New Code 2/28/03.
N176	Services provided aboard a ship are covered only when the ship is of U.S. registry and is in U.S. waters. In addition, a doctor licensed to practice in the U.S. must provide the service.	New Code 2/28/03.
N177	We did not send this claim to beneficiary's other insurer. They have indicated no additional payment can be made.	New Code 2/28/03.Modified 6/30/03.
N178	Missing/invalid/incomplete pre-operative photos or visual field results.	New Code 2/28/03.
N179	Additional information has been requested from the member. The charges will be reconsidered upon receipt of that information.	New Code 2/28/03.
N180	This item or service does not meet the criteria for the category under which it was billed.	New Code 2/28/03.
N181	Additional information has been requested from another provider involved in the care of this member. The charges will be reconsidered upon receipt of that information.	New Code 2/28/03.
N182	This claim/service must be billed according to the schedule for this plan.	New Code 2/28/03.
N183	This is a predetermination advisory message, when this service is submitted for payment additional documentation as specified in plan documents will be required to process benefits.	New Code 2/28/03.
N184	Rebill technical and professional components separately.	New Code 2/28/03.
N185	Do not resubmit this claim/service.	New Code 2/28/03.
N186	Non-Availability Statement (NAS) required for this service. Contact the nearest Military Treatment Facility (MTF) for assistance.	New Code 2/28/03.
N187	You may request a review in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.	New Code 2/28/03.

Code	Description	Notes
N188	The approved level of care does not match the procedure code submitted.	New Code 2/28/03.
N189	This service has been paid as a one-time exception to the plan's benefit restrictions.	New Code 2/28/03.
N190	Missing/incomplete/invalid contract indicator.	New Code 2/28/03.
N191	The provider must update insurance information directly with payer.	New Code 2/28/03.
N192	Patient is a Medicaid/Qualified Medicare Beneficiary.	New Code 2/28/03.
N193	Specific Federal/state/local program may cover this service through another payer.	New Code 2/28/03.
N194	Technical component not paid if provider does not own the equipment used.	New Code 2/28/03.
N195	The technical component must be billed separately.	New Code 2/28/03.
N196	Patient eligible to apply for other coverage which may be primary.	New Code 2/28/03.
N197	The subscriber must update insurance information directly with payer.	New Code 2/28/03.
N198	Rendering provider must be affiliated with the pay-to provider.	New Code 2/28/03.
N199	Additional payment approved based on payer-initiated review/audit.	New Code 2/28/03.
N200	The professional component must be billed separately.	New Code 2/28/03.
N201	A mental health facility is responsible for payment of outside providers who furnish these services/supplies to residents.	New Code 2/28/03.
N202	Additional information/explanation will be sent separately.	New Code 6/30/03.
N203	Missing/incomplete/invalid anesthesia time/units.	New Code 6/30/03.
N204	Services under review for possible pre-existing condition. Send medical records for prior 12 months.	New Code 6/30/03.
N205	Information processed was illegible.	New Code 6/30/03.
N206	The supporting documentation does not match the claim.	New Code 6/30/03.
N207	Missing/incomplete/invalid birth weight.	New Code 6/30/03.
N208	Missing/incomplete/invalid DRG code.	New Code 6/30/03.
N209	Missing/invalid/incomplete taxpayer identification.	New Code 6/30/03.
N210	You may appeal this decision.	New Code 6/30/03.
N211	You may not appeal this decision.	New Code 6/30/03.
N212	Charges processed under a Point of Service benefit.	New Code 2/1/04.

REFERENCE H: GLOSSARY

A

Aberrancy - medical services that deviate from what is considered normal or typical when compared to the national average.

Abuse - abuse describes practices that either directly or indirectly, resulting in unnecessary costs to the Medicare Program. Many times abuse appears quite similar to fraud except that it is not possible to establish that abusive acts were committed knowingly, willfully, and intentionally. Although these types of practices may initially be categorized as *abusive* in nature, under certain circumstances they may develop into *fraud* if there is evidence the subject was knowingly and willfully conducting an abusive practice.

Act - usually refers to the Social Security Act.

Additional Development Request (ADR) Letter - a notice from Medicare that a claim submitted by a provider organization cannot be processed without additional information/documentation. The letter identifies the additional information needed and the date by which the information must be received by Medicare.

Adjudication - the process of determining whether a Medicare claim is paid or denied based on the information submitted and the eligibility of the recipient.

Adjustment - an additional payment or correction of records on a previously processed claim.

Administrative Law Judge (ALJ) - hears appeals of denied claims, as well as appeals from proposed Office of Inspector General (OIG) exclusions.

Admission - entry to a hospital or other health care institution as an inpatient.

Advance Beneficiary Notice (ABN) - written notification to a patient, before a service is rendered, that payment may be denied or reduced because the service may not be covered as medically reasonable and necessary.

Advanced Registered Nurse Practitioner (ARNP) - a Registered Nurse (RN) who has advanced education and clinical training in a health care specialty area.

Aged Insured - describes a person age 65 or older who meets the qualifications for Medicare coverage.

Aggrieved Party - a Medicare beneficiary (or estate) who meets the requirements to challenge the validity of a Local Coverage Determination (LCD) or an National Coverage Determination (NCD) by submitting a request for review of the policy.

Ambulatory Surgical Center (ASC) - a freestanding facility, other than a hospital or physician's office, where outpatient surgical and diagnostic services are provided.

American Medical Association (AMA) - a national association that develops and promotes medical practice, research, and education on behalf of patients and physicians.

American National Standard Institute (ANSI) Format - an electronic format used to submit Medicare Part B claim forms to Medicare for payment.

Ancillary Services - professional services provided by a hospital or other inpatient health program, other than room, board, and surgery (e.g., laboratory, X-ray, drugs).

Anti-Kickback Statute - a Federal statute outlawing certain forms of discounts, rebates, and other reductions in price, inducing the purchase of items or services payable by Medicare or Medicaid.

Appeal - the right for an independent, critical examination of a claim. The five levels of appeal permitted for claims denied by carriers include: a review made by carrier personnel not involved in the initial claim determination; a *Hearing Officer (HO) hearing*; an *Administrative Law Judge (ALJ) hearing*, a *Department Appeals Board (DAB) hearing*; and a review by a U.S. District Court judge. A request for a review may be made to the local Medicare carrier by telephone or in writing. Physicians, beneficiaries or their representatives, providers or other suppliers, may request appeals or reviews.

Appellant - an individual who appeals a claim decision.

Approved Charge - the allowed amount based on the Medicare fee schedule or its transition rules; non-participating physician charges are subject to the limiting charge.

Assigned Claim - a claim submitted to Medicare by a Part B provider who agrees to accept the Medicare-approved charges as payment in full for the rendered service.

Assignment - a physician, provider, or supplier agrees to accept the Medicare fee schedule amount as payment in full for all covered services and the beneficiary agrees to have services paid directly to the physician, provider, or supplier.

Audit - a process to ensure that Medicare reimburses providers based only on costs associated with patient care.

B

Balance Billing, Excess Charge - the difference between the billed amount and the amount allowed by Medicare.

Balanced Budget Act of 1997 (BBA) - the law that changes sections of the Social Security Act, including several anti-fraud and abuse provisions and improvements to protect program integrity.

Beneficiary - a person eligible to receive Medicare or Medicaid payment and/or services.

Benefit Period - the measure of a Medicare beneficiary's use of hospital and Skilled Nursing Facility (SNF) services.

Billed Amount - the amount charged for each service performed by the provider.

Billing Service - a company that, for a fee, furnishes billing, collection, and/or claim filing services for physicians and/or suppliers.

Blue Cross and Blue Shield Association (BCBSA) - non-profit corporation representing the Blue Cross and Blue Shield plans on a national level as a coordinating agency in marketing, government relations, and other system wide initiatives; owns the Blue Cross Blue Shield mark and sets approval standards.

Business Associate - an individual such as a contractor or supplier who is associated with an employer in a business relationship.

C

Calendar Year (CY) - the period of January 1st through December 31st.

Capitation Rate - the fixed amount that Centers for Medicare & Medicaid Services (CMS) pays to an approved managed care plan selected by an enrolled Medicare beneficiary.

Carrier - a contractor for the Centers for Medicare & Medicaid Services (CMS) that determines reasonable charges, accuracy, and coverage for Medicare Part B services and processes Part B claims and payments.

Carrier Advisory Committee (CAC) - a formal mechanism for physicians to be informed of and participate in the development of a Local Medical Review Policy (LMRP) process in an advisory capacity. This group also discusses ways to improve administrative policies that are within carrier discretion.

Centers for Medicare & Medicaid Services (CMS) - a Federal agency that is part of the Department of Health and Human Services (DHHS). Administers and oversees the Medicare Program and a portion of the state Medicaid Program. Responsibilities include managing contractor claims payment, fiscal audit and/or overpayment prevention and recovery, and developing and monitoring payment safeguards necessary to detect and respond to payment errors or abusive patterns of service delivery.

Certificate of Medical Necessity (CMN) - certain Medicare-covered services such as ambulance, cataract glasses, Durable Medical Equipment (DME), and other services require a signed physician's statement authenticating that the items or services were medically necessary.

Certified Provider - a physician, other individual, or entity meeting certain quality standards that provides outpatient self-management training services and other Medicare covered items and services.

Claim - a request for payment of Medicare benefits or services rendered by a provider or received by a beneficiary.

Clearinghouse - an organization, usually national, that, for a fee, receives and sorts provider claims and forwards them to the correct Medicare contractor or commercial insurer.

Clinical Laboratory Improvement Amendments (CLIA) - legislation passed in 1988 that set quality and performance standards for all laboratory testing. CLIA standards are national and are not Medicare-exclusive. CLIA applies to all providers rendering clinical laboratory and certain other diagnostic services, whether or not claims are filed to Medicare.

Coinsurance, Copayment - the amount that Medicare will not pay; the beneficiary or the beneficiary's supplemental insurance company is responsible for paying coinsurance to the physician.

Community Mental Health Center (CMHC) - a facility that provides outpatient mental health services to individuals residing within a specific geographic area.

Concurrent Care - certain emergency/medical services that are rendered by more than one physician with the same or similar specialty on the same date of service.

Consultation - examination by an additional physician or specialist, at the request of a referring physician, the patient, or the patient's family.

Contractor - a state or private health insurer that processes Medicare claims and makes payments to providers of services and to beneficiaries. See also Carrier, Durable Medical Equipment Regional Carrier (DMERC), and Fiscal Intermediary.

Copayment - see Coinsurance.

Coordination of Benefits (COB) - the Centers for Medicare & Medicaid Services (CMS) COB program helps identify beneficiary health care coverage that should pay primary to Medicare. The COB contractor supports the collection management and reporting of other insurance coverage so that beneficiary health care expenses are properly paid while protecting the Medicare Trust Fund assets. Coverage - describes what items and services are payable by a health insurance plan.

Coverage Provisions in Interpretive Manuals - national coverage instructions published by the Centers for Medicaid & Medicare Services (CMS) that are not considered to be National Coverage Determinations (NCDs). They are used to further define when, and under what circumstances, services may be covered or not covered under Medicare. Once published, they are binding on all providers.

Covered Services - reasonable and medically necessary services, rendered to Medicare or Medicaid patients, and reimbursable to the provider or beneficiary.

Critical Access Hospital (CAH) - established as part of the Balanced Budget Act Medicare Rural Hospital Flexibility Program to replace the Essential Access Community and Rural Primary Care Hospital Programs.

Crossover Claims - Medicare claims that are also covered by other insurance (e.g., Medigap, private insurance).

Current Dental Terminology (CDT) - codes required by the Health Insurance Portability and Accessibility Act (HIPAA) to indicate dental services that are developed and maintained by the American Dental Association (ADA).

Current Procedural Terminology (CPT-4) - this Fourth Edition is a set of codes, descriptions, and guidelines used to describe procedures and services performed by physicians and other healthcare providers. Each procedure or service is identified with a five-digit code. Health Insurance Portability and Accessibility Act (HIPAA)-mandated that CPT-4 be used for electronic transactions. CPT-4 is developed and managed by the American Medical Association (AMA).

D

Date of Service - the date a service was actually performed.

Decisions, Determinations - if a Medicare appeal request does not result in a dismissal, adjudication of the appeal results in either a “determination” or “decision”. There is no apparent practical distinction between these two terms, although applicable regulations use the terms in distinct context. Medicare regulations use the term “determination” in the following appeals contexts: Initial determination; reconsideration or review determination; limitation on liability determination; and provider, physician or supplier refund determination. A determination that is reopened and thereafter revised is called a “revised determination”. Medicare regulations use the term “decision” in the following appeals contexts: Hearing Officer (HO) hearing decision; Administrative Law Judge (ALJ) hearing decision; Departmental Appeals Board decision; and administrator decision. A decision that is reopened and thereafter revised is called a “revised decision”.

Deductible - amount a beneficiary must pay before Medicare begins to pay for covered services and supplies.

Denial - nonpayment of a processed claim for an identified technical or medical necessity reason.

Department of Health and Human Services (DHHS) - administers many of the Federal “social” programs dealing with the health and welfare of citizens of the United States; parent agency of the Centers for Medicare & Medicaid Services (CMS).

Diagnosis - an identification of the patient's condition, cause, or disease.

Diagnosis Code - code assigned to the medical terminology used for each service and/or item provided by a provider or health care facility (as noted in the medical records) into a code.

Diagnosis Related Group (DRG) - a system that groups patients according to principal diagnosis, presence of a surgical procedure, age, presence or absence of significant complications, etc.

Disabled Insured - describes a person under age 65 (and some family members) who meet the qualifications for Medicare coverage related to the disability.

Dismissal - a request for appeal may be dismissed for any number of reasons, including: Abandonment of the appeal by the appellant; a request is made by the appellant to withdraw the appeal; an appellant is determined to not be a proper part; the amount in controversy requirements have not been met; or the appellant has died and no one else is prejudiced by the claims determination. A dismissal of a request for review may not be appealed. A Hearing Officer (HO) dismissal may not be appealed. An HO dismissal may not be appealed, however, for good cause shown, an HO may vacate (i.e., set aside or rescind) his or her order of dismissal within six months of the date of the dismissal. An Administrative Law Judge's (ALJ's) dismissal may be vacated by the ALJ or the Departmental Appeals Board for good cause within 60 days after the date of receipt of the dismissal notice.

Documentation Guidelines (DGs) - prescribe the correct use of Evaluation and Management Service (E/M) codes used by all types of physicians.

Duplicate Claims - billing for the same service more than once; Medicare may remove physicians who repeatedly submit duplicate claims from the electronic billing network.

Durable Medical Equipment (DME) - reusable medical equipment ordered by a physician for use in a beneficiary's home (e.g., walker, wheelchair, hospital bed).

Durable Medical Equipment Regional Carrier (DMERC) - a contractor for the Centers for Medicare & Medicaid Services (CMS) that provides Medicare claims processing and payment of Durable Medical Equipment (DME), prosthetics, orthotics, and supplies for a designated region of the country.

E

Electronic Funds Transfer (EFT) - an electronic transfer of Medicare payments directly to a provider's financial institution.

Electronic Media Claims (EMC) - the transmission of claims via modem to the contractor, eliminating mailroom processing and manual data entry; payment is released when CMS time requirements are satisfied, resulting in a faster cash flow turnaround for providers.

Electronic Remittance Notice (ERN) - an electronic summarized statement for providers, including payment information for one or more beneficiaries; equivalent to the Medicare Remittance Notice (MRN); see also Medicare Remittance Notice.

Eligible - a term used to describe a person who is qualified to receive Medicare benefits.

Eligibility Date - starting date that Medicare benefits are available.

Emergency - a situation in which a patient requires immediate medical intervention as a result of severe, life-threatening, or potentially disabling conditions.

End-Stage Renal Disease (ESRD) - kidney failure that is severe enough to require lifetime dialysis or a kidney transplant.

End-Stage Renal Disease (ESRD) -Insured - describes a person who could be under age 65 who meets the qualifications for Medicare coverage related to ESRD.

Enrollment - the means by which a person establishes membership in a program or group.

Entitlement - state of meeting all of the requirements for a particular Medicare benefit; the date of entitlement begins at age 65 for most beneficiaries.

Episode of Care - an identified period from the onset to the conclusion of treatment or a payment period. In Medicare, payments for some providers such as hospitals and home health agencies are based upon episodes.

Evaluation and Management Service (E/M) Codes - used by all physicians to explain how the physician gathered and analyzed information about a patient's illness, determined a condition, and devised the best treatment or course of treatment. These codes are a subset of the Current Procedural Terminology (CPT)-4 code set.

Excess Charge - see Balance Billing.

Exclusion - a situation or condition where coverage is disallowed by a subscriber's contract; Department of Health and Human Services (DHHS)/Office of Inspector General (OIG) penalty imposed on a provider, prohibiting the individual from billing Medicare or other government programs.

Exclusion List, Sanctioned Provider List - an Office of Inspector General (OIG) list of providers, individuals, and entities that are excluded from Medicare reimbursement; includes identifying information about the sanctioned party, specialty, notice date, sanction period, and sections of the Social Security Act used in arriving at the determination to impose a sanction.

Experimental, Investigative - any treatment, procedure, equipment, drug, drug usage, device, or supply not generally recognized as accepted medical practice; includes services or supplies requiring federal or other government approval not granted at the time services were rendered.

F

Fee-for-Service - a payment system where providers are paid a specific amount for each service rendered.

Fee Schedule - see Medical Physician Fee Schedule.

Fiscal Intermediary (FI) - a Centers for Medicare & Medicaid Services (CMS) contractor who determines reasonable charges, accuracy, and coverage for Medicare and processes claims and payments.

Fiscal Year (FY) - October 1st through September 30th for Medicare Part A and B.

Fraud - the intentional deception or misrepresentation that an individual knows to be false or does not believe to be true and makes, knowing that the deception could result in some unauthorized benefit to himself or herself or some other person.

G

GA - a modifier used on a claim form to indicate that an Advanced Beneficiary Notice (ABN) form is on file and signed by the patient.

Gaps - see Medicare Gaps.

Group Health Plan (GHP) - a health insurance plan sponsored by either a patient's or the spouse of a patient's employer where a single employer of 20 or more employees is the sponsor and/or contributor to the GHP, or two or more employers are sponsors and/or contributors and at least one of them has 20 or more employees.

GY - a modifier used on a claim form to indicate that the physician, practitioner, or supplier deems the item or service to be statutorily excluded or not meeting the definition of any Medicare benefit, therefore it is non-covered or is not a Medicare benefit.

GZ - a modifier used on a claim form to indicate that the physician, practitioner, or supplier expects the item or service to be denied as not reasonable and necessary and they DO NOT have an Advanced Beneficiary Notice (ABN) signed by the beneficiary on file.

H

Health Care Common Procedure Coding System (HCPCS) - a uniform method for providers and suppliers to report professional services, procedures, and supplies. HCPCS includes Current Procedure Technology (CPT) codes (Level I), national alphanumeric codes (Level II), and local codes (Level III) assigned and maintained by local Medicare contractors.

Health Insurance Claim Number (HIC/HICN) - a unique alphanumeric Medicare entitlement number assigned to a Medicare beneficiary; appears on the Medicare card.

Health Insurance Portability and Accountability Act of 1996 (HIPAA) - also known as the Kennedy-Kasselbaum Bill enacted on August 21, 1996; designed to protect health insurance coverage for workers and their families when they change or lose their jobs; imposes significant changes to anti-fraud and abuse activities; includes provisions designed to save money for health care businesses by encouraging electronic transactions and requiring new safeguards to protect the security and confidentiality of patient health information.

Health Maintenance Organization (HMO) - a form of health insurance that combines a range of coverage on a group basis; a group of doctors and other medical professionals offer care through the HMO for a flat monthly rate with no deductibles; only visits to professionals within the HMO network are covered by the policy, all visits; prescriptions and other care must be cleared by the HMO in order to be covered.

Health Professional Shortage Area (HPSA) - a medically under-served area of a state where physicians receive a 10% bonus payment for all professional physician services [i.e., services subject to the Medicare Physician Fee Schedule (MPFS)].

Hearing Officer (HO) Hearing - an independent determination related to claims where a party has appealed a review decision within six months of the date of notice of the review decision; hearing is rendered by an HO assigned by the contractor; amount in controversy must be at least $100, which can include more than one claim.

Home Health Agency (HHA) - a public or private organization that specializes in giving in-home skilled nursing and other therapeutic services, such as physical therapy.

Homebound - a patient normally unable to leave home; leaving home takes considerable and taxing effort; patient may leave home for medical treatment or short, infrequent absences for non-medical reasons such as a trip to the barber.

Home Health Care - part-time health care services provided in the home for the treatment of an illness or injury. Medicare pays for home care only if the type of care needed is skilled and required on an intermittent basis and is intended to help individuals recover or improve from an illness, not to provide unskilled services over a long period of time.

Hospice - a facility providing pain relief, symptom management, and supportive services to terminally ill people and their families; eligible beneficiary must have a life expectancy of six months or less.

Hospital - an institution with organized medical staff, permanent facilities that include inpatient beds, medical services including physician services and continuous nursing services, to provide diagnosis and treatment for patients with a variety of medical conditions, both surgical and non-surgical.

Hot Line/Help Line - a number that providers and suppliers and the public are encouraged to call to ask questions or to report suspected fraudulent or abusive activities. For example, contact the local Medicare contractor or call the national Department of Health and Human Services (DHHS)/Office of Inspector General (OIG) hotline directly at: 1-800-HHS-TIPS.

I

ICD-9-CM - International Classification of Diseases, 9th Revision, Clinical Modification; a national coding method to enable providers to effectively document the medical condition, symptom, or complaint that is the basis for rendering a specific service.

"Incident to" Services - services rendered by employees of physicians or physician-directed clinics, when the services provided are integral, though incidental, to the physician's professional service and are performed under direct supervision of the physician.

Individual Health Care Practitioner - any physician or non-physician who renders services to Medicare beneficiaries and submits claims to carriers for services rendered. Form CMS-855I is required for enrollment.

Inpatient - an individual who has been admitted at least overnight to a hospital or other health facility for the purpose of receiving a diagnosis, treatment, or other health service.

Inquiry - a written request for information, usually pertaining to claim status or general information, such as deductible or entitlement.

Institutions - Medicare providers such as hospital, Skilled Nursing Facilities (SNFs), and Comprehensive Outpatient Rehabilitation Facilities (CORFs) that submit claims to fiscal intermediaries (FIs).

Investigative, Experimental - any treatment, procedure, equipment, drug, drug usage, device, or supply not generally recognized as accepted medical practice; includes services or supplies requiring Federal or other government approval not granted at the time services were rendered.

J

Judicial Review - part of the Medicare appeals process; if at least $1,000 remains in controversy following the Departmental Appeals Board (DAB) decision, judicial review before a U.S. District Court judge can be considered.

K

Kickback - offering, soliciting, paying, or receiving remuneration for *referrals* of Medicare or Medicaid patients, or for referrals for services or items paid for, in whole or in part, by Medicare or Medicaid; prohibited by the Anti-Kickback Statue.

L

Large Group Health Plan (LGHP) - a health insurance plan which is contributed to by an employer or employee organization having 100 or more employees, or a plan having a least one member which has at least 100 employees.

Licensed Physician - a physician who is authorized to perform services within limitations imposed by the state on the scope of practice; issuance by a state of a license to practice medicine constitutes legal authorization; see also Physician.

Limiting Charge - the maximum amount a non-participating physician may legally charge a Medicare patient for services billed on non-assigned claims.

Local Coverage Determination (LCD) - local coverage policy developed by fiscal intermediaries (FIs) and carriers to describe the circumstances for Medicare coverage for a specific medical service procedure or device within their jurisdiction.

Local Medical Review Policy (LMRP) - a formal statement developed through a specific process by a fiscal intermediary or carrier that defines a procedure or service and provides decision-making criteria for claim review and payment decisions.

Long-term Care - custodial care given at home or in a nursing home for people with chronic disabilities and lengthy illnesses; not covered by Medicare.

M

Managed Care Plan - a system of providing health care that is designed to control costs through managed care programs in which the physician accepts constraints on the amount charged for medical care and the patient is limited in the choice of a physician [e.g., Health Maintenance Organization (HMO), Preferred Provider Organization (PPO)].

Medicaid - Federal/State entitlement program under Title XIX of the Social Security Act that pays for medical assistance for certain individuals and families with low incomes and resources; policies for eligibility, services, and payment are complex and vary considerably, even among states of similar size or geographic proximity.

Medically Necessary Services - services or supplies that are proper and needed for the diagnosis or treatment of an illness or injury, meet standards of good medical practice, and are not provided for the convenience of the patient or the doctor.

Medical Review (MR) - a review of services by contractor medical personnel; includes analysis of claims data to identify potential billing problems resulting in inappropriate utilization situations; includes various plans of action to correct the problem.

Medicare - a Federal health insurance program established by Congress through Title XVIII of the Social Security Act (July 1, 1966) that provides medical coverage for people 65 or older, certain disabled individuals, and most individuals with end-stage renal disease (ESRD).

Medicare Advantage (Formerly Medicare + Choice) - also known as Medicare Advantage or Part C of the Medicare Program; set of healthcare options created by the Balanced Budget Act of 1997 (BBA); “managed care” plan; includes Health Maintenance Organization (HMO), Point of Service (POS), Provider Sponsored Organization (PSO), Preferred Provider Organization (PPO), Medical Savings Account (MSA), religious fraternal benefit society plan (RFP), and private fee-for-service plan.

Medicare-Certified Provider - a physician, other individual, or entity meeting certain quality standards that provides outpatient self-management training services and other Medicare covered items and services.

Medicare Fee Schedule - the resource-based fee schedule that Medicare utilizes to reimburse/pay for physician, laboratory, and supplier services.

Medicare Gaps - the costs or services that are not covered under the Medicare Plan.

Medicare Part A - medical coverage that is generally provided automatically, and free of premiums, to persons age 65 or over who are eligible for Social Security or Railroad Retirement Board (RRB) benefits, whether they have claimed the monthly cash benefits or not, also certain government employees and certain disabled individuals.

Medicare Part B - provides insurance coverage for services by physicians and medical suppliers to persons age 65 or over who are eligible for Social Security or Railroad Retirement Board (RRB) benefits, whether they have claimed the monthly cash benefits or not, also certain government employees and certain disabled individuals.

Medicare Part C - also known as Medicare + Choice; a set of heath care options created by the Balanced Budget Act (BBA); “managed care” plan; includes Health Maintenance Organization (HMO), Point of Service (POS), Provider Sponsored Organization (PSO), Preferred Provider Organization (PPO), Medical Savings Account (MSA), religious fraternal benefit society plan (RFP), and private fee-for-service plan.

Medicare Part D - provides beneficiaries with a Medicare drug benefit through private health plans. Anyone enrolled in Medicare Parts A or B are eligible to join Part D. Beneficiaries can elect to receive prescription drug coverage through either drug-only or a Medicare Advantage plan that provides comprehensive benefits.

Medicare Physician Fee Schedule (MPFS) - a complete list of medical procedure codes and the maximum dollar amounts Medicare will allow for each service rendered for a beneficiary. MFS is based on the calculation of several components, including relative value unit (RVU), which is based on three factors: the physician's work, overhead expenses, and malpractice insurance.

Medicare Remittance Notice (MRN) - a paper summarized statement for providers, including payment information for one or more beneficiaries; equivalent to the Electronic Remittance Notice (ERN); also see ERN.

Medicare Secondary Payer (MSP) - the term used when Medicare is not responsible for paying first on a claim; some individuals have other insurance or coverage that must pay before Medicare pays [e.g., Group Health Plan (GHP)].

Medicare Summary Notice (MSN) - a statement sent to a Medicare beneficiary that indicates how Medicare processed the claim.

Medicare Trust Fund - a U.S. Department of Treasury account established by the Social Security Act for the receipt of revenues, maintenance of reserves, and disbursement of payments for the Medicare Program.

Medigap - Medicare supplemental health insurance policies sold by private insurance companies and designed to supplement, or fill “gaps” in, Medicare coverage; such policies usually, but not always, feature coverage of copayments and deductibles,

MEDPARD Directory - state and county directory that contains names, addresses, and specialties of Medicare participating physicians who have agreed to accept assignment on all Medicare claims and covered services.

Modifier - a two-digit alphanumeric code used in conjunction with a procedure code to provide additional information about the service, may affect reimbursement of services.

N

National Coverage Determination (NCD) - National coverage policy developed by the Centers for Medicare & Medicaid Services (CMS) to describe the circumstances for Medicare coverage for a specific medical service, procedure, or device.

National Drug Code (NDC) - code(s) required by the Health Insurance Portability and Accountability Act (HIPAA) to indicate drugs and biologics used in retail pharmacy transactions.

National Standard Format (NSF) - the standardized electronic format used to submit Medicare Part B claim forms.

Non-Assigned Claim - a type of claim that may only be filed by a non-participating Medicare physician; when a claim is filed non-assigned the beneficiary is reimbursed directly.

Non-Participating Provider - a physician, provider, or supplier who does not agree to accept Medicare's allowed amount as payment in full and may charge the beneficiary, up to the limiting charge, for the service(s); may accept assignment of Medicare claims on a case-by-case basis.

Non-Physician Practitioner - a health care provider who meets state licensing requirements to provide specific medical services. Medicare allows payment for services furnished by non-physician practitioners, including but not limited to advance registered nurse practitioners (ARNPs), clinical nurse specialists (CNSs), licensed clinical social workers (LCSWs), physician assistants (PAs), nurse midwives, physical therapists, and audiologists.

Normal/Reasonable - applying normal collection processes to Medicare as well as non-Medicare patients.

Notice of Exclusion of Medicare Benefits (NEMB) - a voluntary notice that a provider may furnish to a beneficiary to identify that Medicare will not pay for particular items or services that are not part of the Medicare benefit, before the items or services are furnished to the beneficiary.

O

Occupational Therapy (OT) - various services and treatments provided to help a patient return to his or her usual activities of daily living (e.g., bathing, preparing meals, and housekeeping) after an illness or injury, either on an inpatient or outpatient basis.

Office of the Inspector General (OIG) - an organizational component of the Office of the Secretary, Department of Health and Human Services (DHHS); responsible for conducting and supervising audits, investigations, and inspections relating to the programs and operations of DHHS, including Medicare and Medicaid. OIG provides leadership and coordination, recommends policies and corrective actions, prevents and detects fraud and abuse in DHHS programs and operations, and is responsible for all DHHS criminal investigations, including Medicare fraud, whether committed by contractors, grantees, beneficiaries, or providers of service.

Open Enrollment Period - the one opportunity each year when physicians may change participation status for the following calendar year (CY), usually in November.

Optical Character Recognition (OCR) - automated scanning process similar to scanners that read price labels in grocery stores; some contractors use OCR to scan claims information for further processing.

Original Medicare - the traditional fee-for-service Medicare Part A and Part B plans are considered as Original Medicare Plans.

Out-of-Plan Provider - beneficiaries in certain Medicare Advantage plans require services to be furnished by a provider that is under contract with the plan. If a provider does not have an agreement with the plan, they are considered to be an out-of-plan provider and their services may not be paid for by the plan.

Outpatient - a patient who receives care at a hospital or other health facility without being admitted to the facility; outpatient care also refers to care given in organized programs, such as outpatient clinics.

Overpayment - when Medicare funds that a physician, supplier, or beneficiary has received are in excess of amounts due and payable under Medicare statute and regulations; the amount of the overpayment is a debt owed to the U.S. Government.

P

Part A - coverage that is generally provided automatically, and free of premiums, to persons age 65 or over who are eligible for Social Security or Railroad Retirement Board (RRB) benefits, whether they have claimed the monthly cash benefits or not, also certain government employees and certain disabled individuals.

Part B - provides insurance coverage for services by physicians and medical suppliers to persons age 65 or over who are eligible for Social Security or Railroad Retirement Board (RRB) benefits, whether they have claimed the monthly cash benefits or not, also certain government employees and certain disabled individuals.

Part C - a set of heath care options created by the Balanced Budget Act (BBA); “managed care” plan; includes Health Maintenance Organization (HMO), Point of Service (POS), Provider Sponsored Organization (PSO), Preferred Provider Organization (PPO), Medical Savings Account (MSA), religious fraternal benefit society plan (RFP), and private fee-for-service plan.

Part D - provides beneficiaries with a Medicare drug benefit through private health plans. Anyone enrolled in Medicare Parts A or B are eligible to join Part D. Beneficiaries can elect to receive prescription drug coverage through either drug-only or a Medicare Advantage plan that provides comprehensive benefits.

Participating Physician - physician who signs a participation agreement to accept assignment on all claims submitted to Medicare.

Participation Program - Medicare Program in which a physician voluntarily enters into an agreement to accept assignment for all services provided to Medicare patients.

Patient - a person under treatment or care, by a physician or other individual practitioner, in a hospital or other health care facility.

Peer Review Organization (PRO) - an organization contracting with CMS to review the medical necessity and quality of care provided to Medicare beneficiaries. Sometimes referred to as a Quality Improvement Organization (QIO).

Physician - an individual licensed under state law to practice medicine or osteopathy.

Physician Assistant (PA) - a specially trained and licensed individual who performs tasks usually done by physicians and works under the direction of a supervising physician.

Physician Associate (PA) Group - a partnership, association, or corporation composed of two or more physicians and/or non-physician practitioners who wish to bill Medicare as a unit.

Place of Service (POS) - the location where a service is performed, such as a hospital (inpatient or outpatient), doctor's office, or Skilled Nursing Facility (SNF).

Plan of Care - a physician's written plan stating the kind(s) of service(s) and care a beneficiary needs for his or her health problem.

Preferred Provider Organization (PPO) - a managed care plan in which the patient uses physicians, hospitals, and providers that belong to a network.

Premium - the amount a beneficiary regularly pays to Medicare, an insurance company, or a health care plan for health care coverage.

Preventive Care - services used to keep a beneficiary healthy or to prevent illness, such as Pap smears, mammograms, prostate and colorectal cancer screenings, and influenza and pneumonia vaccinations.

Primary Payer - the insurer (private or governmental) that pays first on a claim for medical care.

Prior Authorization - beneficiaries in certain Medicare Advantage plans require prior approval from the plan for certain services to be paid for by the plan.

Procedure - an established series of steps used to eliminate a health problem or to learn more about it (e.g., surgery, tests, inserting an intravenous line) that is represented by a Procedure Code for payment purposes.

Procedure Code - the alphanumeric representation of a procedure used to determine reimbursement for services rendered on a claim form and other medical documentation. The Health Insurance Portability and Accountability Act (HIPAA) has identified the Current Procedural Terminology (CPT-4) and Health Care Common Procedure Coding System (HCPCS) as the only procedure code sets permitted in electronic transactions.

Professional Component - a diagnostic test situation where the physician interprets but does not perform the test.

Prognosis - prediction of a probable course of a disease and the chances of recovery.

Progressive Corrective Action (PCA) - a process used to identify and prevent Medicare fraud and abuse that involves data-driven Medical Review (MR) and provider education activities.

Prosecute - to submit a charging document to a court; seek a grand jury indictment against person(s) accused of committing criminal offenses.

Prospective Payment System (PPS) - mandated by the Balanced Budget Act of 1997 (BBA); changes Medicare payments from cost-based to prospective, based on national average capital costs per case. PPS helps Medicare control its spending by encouraging providers to furnish care that is efficient, appropriate, and typical of practice expenses for providers. Patients and resource needs are statistically grouped, and the system is adjusted for patient characteristics that affect the cost of providing care. A unit of service is then established, with a fixed, predetermined amount for payment.

Provider - a physician, health care professional, hospital, or healthcare facility approved to furnish care to Medicare beneficiaries and to receive payment from Medicare.

Provider Identification Number (PIN) - a unique individual billing number issued to a provider by the local Medicare contractor, allowing the physician or patient to receive reimbursement for claims filed to the contractor.

Purchased Diagnostic Test - a test, such as an EKG, X-ray, or ultrasound, purchased from an outside supplier; the physician does not personally perform or supervise the test.

Q

Quality Improvement Organization (QIO) - organization contracting with the Centers for Medicare & Medicaid Services (CMS) to review medical necessity and quality of care provided to Medicare beneficiaries

Quality Assurance - process of determining how well a medical service is provided. The QA process may include formal review of healthcare provided, locating and correcting any problems, and verifying that corrections have eliminated the problem(s) found.

Qui Tam - the “Whistle Blower” or “qui tam” provision allows any person having knowledge of a false claim against the government to bring an action against the suspected wrongdoer on behalf of the United States Government. A person who files a “qui tam” suit on behalf of the government is known as a “relator” and may share a percentage of the recovery realized from a successful action.

R

Reasonable/Normal - applying normal collection processes to Medicare as well as non-Medicare patients.

Reassignment of Benefit - individual health care practitioners enrolled in a group practice or clinic that bills a carrier must state that they agree to turn monies over to the group/clinic for services furnished for the group/clinic. Form CMS-855R is required for enrollment.

Referral - specialty, inpatient, outpatient, or laboratory services that are ordered or arranged, but not furnished directly; approval from a beneficiary's primary or other physician to see a specialist or receive certain services.

Regional Home Health Intermediary (RHHI) - organization that contracts with Medicare to pay home health bills and to audit home health physicians.

Regional Office (RO) - one of ten Centers for Medicare & Medicaid Services (CMS) offices located nationwide that provide policy guidance and oversight to Medicare payment contractors [fiscal intermediaries (FIs) and carriers] within their regions.

Rejection - the claim was not processed for payment and was returned to the provider due to missing or incorrect elements.

Relative Value - reflects the relativity in units of median charges among procedures, in any of the five major categories of medicine.

Relator - a person who files a qui tam suit on behalf of the government; see “Qui Tam” or Whistle Blower.

Remittance - the payment of a Medicare claim by a Medicare contractor.

Remittance Notice - a summarized statement for providers, including payment information for one or more beneficiaries. See also Medicare Remittance Notice (MRN).

Resident - for Medicare purposes, a physician who is participating in an approved Graduate Medical Education (GME) training program or one who is not in an approved program but who is authorized to practice only in a hospital setting.

Restitution - a court-ordered giving or returning of funds.

Review - 1) an independent, critical examination of a claim made as a result of an appeal; 2) an administrative process that results when an “aggrieved party” challenges a coverage policy such as a Local Coverage Determination (LCD) or National Coverage Determination (NCD).

Rights - Medicare beneficiaries are guaranteed certain rights or protections including: privacy; treatment options; itemized statements; information regarding treatments; access to needed services; and appeals.

S

Sanction - a situation or condition where coverage is disallowed by a subscriber's contract; Department of Health and Human Services (DHHS)/Office of Inspector General (OIG) penalty imposed on a provider, prohibiting the individual from billing Medicare or other government programs.

Sanctioned Provider List - an Office of Inspector General (OIG) list of providers, individuals, and entities that are excluded from Medicare reimbursement; includes identifying information about the sanctioned party, specialty, notice date, sanction period, and sections of the Social Security Act used in arriving at the determination to impose a sanction.

Screening Test - an examination for early detection of a specific disease; Medicare pays for specific routine screenings, such as Pap smears, mammograms, prostate cancer screenings, and colorectal cancer screenings.

Services - procedures furnished that are represented by Current Procedural Terminology (CPT-4) or Health Care Common Procedure Coding System codes on a claim.

Skilled Nursing Facility (SNF) - an institution or distinct part of an institution having a transfer agreement with one or more hospitals; primarily engaged in providing inpatient skilled nursing care or rehabilitation services.

Social Security Administration (SSA) - the Federal agency that administers various programs funded under the Social Security Act; determines eligibility for Medicare benefits.

State Health Insurance Assistance Program (SHIP) - local specially-trained staff and volunteer counselors that provide personal health insurance counseling to beneficiaries. Services are free, unbiased, and confidential.

Supplier - an entity that provides Durable Medical Equipment (DME) or items such as a wheelchair or portable X-ray.

Supplies - devices or equipment that provide a health benefit.

Supplemental Insurance - a policy purchased by a beneficiary to help pay charges, such as deductibles, coinsurance, and excluded services, that Medicare does not pay.

Surrogate UPIN - a temporary number (except for those of retired physicians) used if no Unique Physician Identification Number (UPIN) has been assigned to the ordering/referring physician; may be used only until an individual UPIN is assigned.

T

Title XVIII of the Social Security Act - the statutory authority for the Medicare Program.

Title XIX of the Social Security Act - the statutory authority for the Medicaid Program.

Treatment - the action taken to address or prevent a health problem.

U

Unbundled Service - a service that is considered part of the basic allowance of another procedure, but that is billed separately to Medicare. Medicare does not allow billing for incorrect unbundled services.

Unique Physician/Practitioner Identification Number (UPIN) - a six-character alphanumeric code, assigned by the Centers for Medicare & Medicaid Services (CMS) to each Medicare provider and used to identify a referring physician. This number is NEVER used as a provider billing number.

United States, U.S. - for Medicare coverage purposes, 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.

Unprocessable Claim - a claim that cannot be processed due to certain incomplete or incorrect information.

Upcoding - a potentially fraudulent activity that involves claims submitted to Medicare for non-covered/non-chargeable services, supplies, or equipment in a way that makes it appear that Medicare covered services, supplies, or equipment were provided.

Utilization - the percentage of usage by Medicare patients of a particular facility's or health care provider's services.

Utilization Review - the process of verifying medical necessity of services furnished or ordered by a physician or other provider.

V

Vendor - an individual or entity that provides hardware, software, and/or ongoing support services for providers to file claims electronically to Medicare.

W

Whistle Blower - the “Whistle Blower” or “qui tam” provision allows any person having knowledge of a false claim against the government to bring an action against the suspected wrongdoer on behalf of the U. S. Government. A person who files a qui tam suit on behalf of the government is known as a “relator” and may share a percentage of the recovery realized from a successful action.

REFERENCE I: ACRONYMS

ABN	Advanced Beneficiary Notice
ADA	American Dental Association
ADR	Additional Development Request
ALJ	Administrative Law Judge
AMA	American Medical Association
ANSI	American National Standards Institute
ARNP	Advanced Registered Nurse Practitioner
ASC	Ambulatory Surgical Center
BBA	Balanced Budget Act
BCBSA	Blue Cross Blue Shield Association
CAH	Critical Access Hospital
CCN	Correspondence Control Number
CEO	Chief Executive Officer
CF	Conversion Factor
CLIA	Clinical Laboratory Improvement Amendments
CMN	Certificate of Medical Necessity
CMP	Civil Monetary Penalty
CMS	Centers for Medicare & Medicaid Services
CMSPCS	Centers for Medicare & Medicaid Services Procedure Coding System
CNS	Clinical Nurse Specialist
COB	Coordination of Benefits
CORF	Comprehensive Outpatient Rehabilitation Facility
CPT	Current Procedural Terminology
CRNA	Certified Registered Nurse Anesthetist
CWF	Common Working File
CY	Calendar Year
DG	Documentation Guideline
DHEW	Department of Health, Education, and Welfare
DHHS	Department of Health and Human Services
DME	Durable Medical Equipment
DMERC	Durable Medical Equipment Regional Carrier
DRE	Digital Rectal Examination
DSMO	Designated Standards Maintenance Organizations
DO	Doctor of Osteopathy
DOJ	Department of Justice
DRG	Diagnosis Related Group
EACH	Essential Access Community Hospital
ECS	Electronic Claims Status
EDI	Electronic Data Interchange
EFT	Electronic Funds Transfer
EIN	IRS Employer Tax ID
E/M	Emergency Medical Services
EMC	Electronic Media Claims
EOB	Explanation of Benefits
ERA	Electronic Remittance Advice
ERN	Electronic Remittance Notice
ESRD	End-Stage Renal Disease

FAQ	Frequently Asked Question
FBI	Federal Bureau of Investigation
FDA	Food and Drug Administration
FI	Fiscal Intermediary
FLP	Financial Liability Protection
FMR	Focused Medical Review
FQHC	Federally Qualified Health Center
GHP	Group Health Plan
GME	Graduate Medical Education
GPCI	Geographic Practice Cost Index
GPO	Government Printing Office
GSA	General Services Administration
HCFA	Health Care Financing Administration
HCPCS	Healthcare Common Procedure Coding System
HHA	Home Health Agency
HHABN	Home Health Advance Beneficiary Notice
HI	Hospital Insurance
HIC or HICN	Health Insurance Claim Number
HINN	Hospital-Issued Notice of Non-Coverage
HIPAA	Health Insurance Portability and Accountability Act
HMO	Health Maintenance Organization
HO	Hearing Officer
HPSA	Health Professional Shortage Area
ICD-9-CM	International Classification of Disease - Ninth Edition, Clinical Modification
ICN	Internal Control Number
IDE	Investigational Device Exemption
IDTF	Independent Diagnostic Testing Facilities
IRP	Incentive Reward Program
IRS	Internal Revenue Service
IT	Information Technology
LCD	Local Coverage Determination
LCSW	Licensed Clinical Social Worker
LEIE	List of Excluded Individuals/Entities
LGHP	Large Group Health Plan
LMRP	Local Medical Review Policy
LOL	Limitation on Liability
LTC-DRG	Long Term Care - Diagnosis Related Grouping
MD	Doctor of Medicine
MDC	Major Diagnostic Category
MMA	Medicare Modernization Act
MNT	Medical Nutritional Therapy
MPFS	Medicare Physician Fee Schedule
MR	Medical Review
MRN	Medicare Remittance Notice
MSA	Medical Savings Account
MSP	Medicare Secondary Payer
MSN	Medicare Summary Notice
MTF	Military Treatment Facility
NCCI	National Correct Coding Initiative
NCD	National Coverage Determination

NDC	National Drug Code
NEMB	Notice of Exclusion of Medical Benefits
NMES	Neuromuscular Electrical Stimulation
NOC	Not Otherwise Classified
NONC	Notice of Non-Coverage
NP	Nurse Practitioner
NPI	National Provider Identifier
NPWP	Negative Pressure Wound Therapy
NSC	National Supplier Clearinghouse
NSF	National Standard Format
OBRA	Omnibus Budget Reconciliation Act
OCR	Optical Character Recognition
OCR	Office for Civil Rights
OHA	Office of Hearings and Appeals
OIG	Office of Inspector General
OT	Occupational Therapy
PA	Physician's Assistant
PCA	Progressive Corrective Action
PCS	Provider Claim Summary
PI	Program Integrity
PIN	Provider Identification Number
POS	Place of Service OR Point of Service (with Medicare Advantage plans)
POV	Power Operated Vehicle
PPO	Preferred Provider Organization
PPR	Physician Payment Reform
PPS	Prospective Payment System
PRO	Professional Review Organization
PSO	Provider Sponsored Organization
PT	Physical Therapist
QC	Quarter of Coverage
QDWI	Qualified Disabled and Working Individual
QIO	Quality Improvement Organization
QMB	Qualified Medicare Beneficiary
RA	Remittance Advice
RBRVU	Resource-Based Relative Value Unit
RFP	Religious Fraternal Benefit Society Plan
RHHI	Regional Home Health Intermediary
RR	Refund Requirement
RRB	Railroad Retirement Board
RUG	Resource Utilization Grouping
SCHIP	State Children's Health Insurance Program
SDO	Standards Development Organization
SHIP	State Health Insurance Assistance Programs
SLMB	Specified Low-income Medicare Beneficiary
SMI	Supplementary Medical Insurance
SNF	Skilled Nursing Facility
SOF	Signature on File
SPR	Standard Paper Remittance
SRS	Social and Rehabilitation Service
SSA	Social Security Administration

SSN	Social Security Number
SVRS	Statistically Valid Random Sample
TIN	Tax Identification Number
UMW	United Mine Workers
UPIN	Unique Physician Identification Number
VHA	Veterans Health Administration
WC	Workers' Compensation

REFERENCE J: WEBSITES AND PHONE NUMBERS

Please note that all information listed below was accurate per the Centers for Medicare & Medicaid Services (CMS) website at the time of printing; however, this information is subject to change.

Web Page References	
Foreword	
CMS Web Page	http://www.cms.hhs.gov
Part 1 - Introduction to Medicare	
Medicare Learning Page	http://www.cms.hhs.gov/MLNGenInfo
Updated 2003 Medicare Legislation	http://www.cms.hhs.gov/MMAupdate
Medicare Publications and Latest Drug Card Information	http://www.cms.hhs.gov/PrescriptionDrugCovGenInfo
Medicare Modernization Act (MMA) Information	http://www.Medicare.gov/MedicareReform
CMS Regional Office (RO) Information	http://www.cms.hhs.gov/RegionalOffices
Directory of Fiscal Intermediaries (FIs) and Carriers	http://www.cms.hhs.gov/apps/contacts/incardir.asp The contacts database is the primary source for all contact information on the CMS website. It is verified quarterly and updated on a monthly basis.
Medicare Personal Plan Finder Tool	http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/03_Resources.asp
Part 2 - Becoming a Medicare Provider	
List of Current Contractors	http://www.cms.hhs.gov/MedicareProviderSupEnroll/
CMS Provider Enrollment Forms and Guidance for Completing These Forms	http://www.cms.hhs.gov/ProviderSupEnroll/03_EnrollmentApplications.asp
Medicare Resident & New Physician Training Guide	http://www.cms.hhs.gov/MNProducts
List of Current Carriers	http://www.cms.hhs.gov/MedicareProviderSupEnroll/PSEC/list.asp
Part 3 - Submitting Medicare Claims	
Carrier and Durable Medical Equipment Regional Carrier (DMERC) Electronic Data Interchange (EDI) Help Lines	http://www.cms.hhs.gov/ElectronicBillingEDITrans/03_EDISupport.asp
The CMS Standard EDI Enrollment Form in Portable Data Format (PDF)	http://www.cms.hhs.gov/MecicareProviderSupEnorl/downloads/cms855il.pdf
National Correct Coding Initiative (NCCI) Information	http://www.cms.hhs.gov/physicians/cciedits/

Web Page References (Con't)	
Part 3 - Submitting Medicare Claims (Con't)	
Provider Claim Forms	http://www.cms.hhs.govMedicareProviderSupEnroll/downloads/cms855iasp
The Government Printing Office (GPO)	http://bookstore.gpo.gov
Claim Adjustment Reason Codes and Remittance Advice (RA) Remark Codes	http://www.wpc-edi.com/codes
End-Stage Renal Disease (ESRD) Entitlement Information	http://www.medicare.gov/Publications/Pubs/pdf/10128.pdf
Medicare Benefit Policy Manual, Chapter 16, §50.1	http://www.cms.hhs.gov/manuals/IOM/list.asp
Medicare Secondary Payer (MSP) Provider Billing Requirements Manual	http://www.cms.hhs.gov/manuals/IOM/list.asp
Frequently Asked Questions (FAQs) for Coordination of Benefits (COB) or MSP	questions.cms.hhs.gov/ .
Beneficiaries Notification Initiative and Current Advance Beneficiary Notification (ABN) Forms	http://www.cms.hhs.gov/BNI
Instructions for Completing ABN Forms	http://www.cms.hhs.gov/manuals/104_claims/clm104c30.pdf Instructions are included within Chapter 30 of the *Medicare Claims Processing Manual*.
Healthcare Common Procedure Coding System (HCPCS) Codes	http://www.cms.hhs.gov/medicare/hcpcs/default.asp
National Correct Coding Initiative (NCCI) Edits & Policy Manual (Updated Quarterly)	http://www.cms.hhs.gov/physicians/cciedits/
Medicare Secondary Payer (MSP) Patient and Staff Education	http://www.medicare.gov/Publications/Home.asp
Part 4 - Protecting Medicare from Fraud and Abuse	
Current National Coverage Determinations (NCDs)	http://www.cms.hhs.gov/ncdindexes.asp
Required Local Medical Review Policy (LMRP) Format for All New LMRPs	http://www.cms.hhs.gov/mcd/search.asp/
Medicare Coverage Database Containing Draft and Final LMRPs	http://www.cms.hhs.gov/mcd/search.asp?
Medical Program Integrity Manual	http://www.cms.hhs.gov/manuals/IOM/list.asp
Incentive Reward Program (IRP) Information	http://www.cms.hhs.gov/manuals/108_pim/pim83c02.pdf Please refer to Section 3.6 on this website for more information.
Provider Enrollment Forms	http://www.cms.hhs.gov/providers/enrollment/forms/

Web Page References (Con't)	
Part 4 - Protecting Medicare from Fraud and Abuse (Con't)	
Department of Health and Human Services (DHHS) Office of Inspector General (OIG) Exclusions Program	http://www.oig.hhs.gov/fraud/exclusions.html
The OIG Sanctioned List of Excluded Individuals/Entities (LEIE)	Go to http://www.oig.hhs.gov/ on the Web. Once at this address, click on "Exclusions Database".
List of Latest Claims Adjustment Reason and Remark Codes	http://www.wpc-edi.com/codes/Codes.asp
General Services Administration (GSA) Disbarred/Excluded/Suspended Parties List	http://www.epls.gov
Part 5 - Troubleshooting Denials and Claim Rejections	
Form CMS-1500 Crosswalk Between Electronic and Paper Claim Forms	http://www.cms.hhs.gov/manuals/IOM/list/asp
Social Security Act Coverage Policy Denials	http://www.ssa.gov/OP_Home/ssact/title18/1862.htm
Coordination of Benefits (COB) Contractor Information	http://www.cms.hhs.gov/medicare/cob/msp/msp_home.asp
Medicare Coverage Database Containing Local Medical Review Policies (LMRPs) and Local Coverage Determinations (LCDs) Database	http://www.cms.hhs.gov/mcd
Claim Denial Appeals Process Information	http://www.cms.hhs.gov/manuals/104_claims/clm104c29.pdf
CMS-1964 Request for Review Form	http://www.cms.gov/forms/cms1964.pdf
Procedures for Challenging a National Coverage Determination (NCD)	http://www.cms.hhs.gov/coverage
Part 6 - Introduction to HIPAA	
Covered Entity Decision Tools	http://www.cms.hhs.gov/hipaa/hipaa2/support/tools/decisionsupport/default.asp
Office for Civil Rights Health Insurance Portability and Accountability Act (HIPAA) and Covered Entity Information	http://www.hhs.gov/ocr/hipaa/
HIPAA Administrative Simplification - Transaction Regulations and Standards, Final Rules, Code Sets, and Identifier Information	http://www.cms.hhs.gov/hipaa/hipaa2/regulations/
Guidance for Creating Electronic Claims	http://www.wpc-edi.com/hipaa/HIPAA_40.asp
Evaluation and Management Service (E/M) Codes	http://www.cms.hhs.gov/MLNProdusts/MP/list.asp

Web Page References (Con't)	
Part 6 - Introduction to HIPAA (Con't)	
Documentation Guidelines (DGs) for Using E/M Codes	http://www.cms.hhs.gov/MLNGenInfo
Designated Standards Maintenance Organization (DSMO) Information	http://www.hipaa-dsmo.org/
Provider Readiness Checklists and Standards	http://www.cms.hhs.gov/hipaa/hipaa2/default.asp
Exceptions to Medicare Electronic Billing Requirements	http://www.cms.hhs.gov/hipaa/hipaa2/guidance-final.pdf
Latest Regulations Regarding Limited Acceptance of Paper Claims	http://www.cms.hhs.gov/hipaa/hipaa2/general/deadlines.asp
Contingency Planning Guidelines	http://www.cms.hhs.gov/hipaa/hipaa2/general/default.asp#contingency_guide
HIPAA Security Information, Final Rule for Security Standards	http://www.cms.hhs.gov/hipaa/hipaa2/regulations/security/default.asp
Unique Identifier Information	http://www.cms.hhs.gov/hipaa/hipaa2/regulations/identifiers/
HIPAA Privacy Information and Final Rule for Privacy Standards	http://www.cms.hhs.gov/hipaa/hipaa2/regulations/privacy/default.asp#finalrule
HIPAA Privacy Rule Implementation for the Original Medicare Program (Fee-for-Service Medicare)	http://www.cms.hhs.gov/hipaa/hipaa2/regulations/privacy/default.asp
Reference A - Provider Speciality Codes	
List of Provider Specialty Codes	http://www.cms.hhs.gov/providers/enrollment
Reference B - Form CMS-1500	
Portable Document Format (PDF) Version of Form CMS-1500	http://www.cms.hhs.gov/providers/edi/edi5.asp
Fiscal Year (FY) 2004 Updated ICD-9-CM Codes	http://www.cms.hhs.gov/paymentsystems/icd9/default.asp
Reference F - Healthcare Claim Adjustment Reason Codes	
List of Healthcare Claim Adjustment Reason Codes	http://www.wpc-edi.com/Codes/Codes.asp
Reference G - Remittance Advice Remark Codes	
List of RA Remark Codes	http://www.wpc-edi.com/Codes/Codes.asp
Identifying Participation Medicare Contractors	http://www.cms.hhs.gov
LMRP Policy Guide	http://www.cms.hhs.gov/mcd

Address and Phone Number References

Where to Find Telephone Contact Information on the CMS Website:

Contact information for entities such as fiscal intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and Durable Medical Equipment Regional Carriers (DMERCs) is available at http://www.cms.hhs.gov/contacts on the Web.

Please note that all information listed below was accurate per the CMS website at the time of printing; however, this information is subject to change.

Part 1 - Introduction to Medicare

Subject	Office/Company and Address	Phone Number
Medicare Beneficiary, State Health Insurance Assistance Program (SHIP), and Prescription Drug Card Resources	N/A	1-800-MEDICARE (1-800-633-4227) TTY/TDD: 1-877-486-2048

Part 3 - Submitting Medicare Claims

Subject	Office/Company and Address	Phone Number
RHHI Addresses and Phone Numbers	Anthem Health Plans of Maine, Inc. 2 Gannett Dr. South Portland, ME 04146-6911	207-822-7000
	Blue Cross and Blue Shield of Alabama P.O. Box 830139 Birmingham, AL 35283-0139	205-988-2100
	Blue Cross and Blue Shield of South Carolina I-20 at Alpine Rd. Columbia, SC 29219	803-788-3860
	United Government Services 401 West Michigan St. Milwaukee, WI 53203-2804	414-226-6203
DMERC Addresses and Phone Numbers	MetraHealth (HealthNow) P.O. Box 6800 Wilkes-Barre, PA 18773-6800	866-419-9458
	AdminaStar Federal, Inc. P.O. Box 7078 Indianapolis, IN 46207-7078	877-299-7900
	Palmetto Government Benefits Administrators Medicare DMERC Operations P.O. Box 100141 Columbia, SC 29202-3141	866-238-9650
	CIGNA Medicare Region D DMERC P.O. Box 690 Nashville, TN 37202	877-320-0390

Address and Phone Number References		
Part 3 - Submitting Medicare Claims (Con't)		
Subject	**Office/Company and Address**	**Phone Number**
Medicare Coordination of Benefits (COB) Contractor	N/A	800-999-1118
Part 4 - Protecting Medicare from Fraud and Abuse		
Subject	**Office/Company and Address**	**Phone Number**
DHHS/OIG Hot Line	N/A	1-800-HHS-TIPS
Part 5 - Troubleshooting Denials and Claim Rejections		
Subject	**Office/Company and Address**	**Phone Number**
DHHS/OIG Hot Line	N/A	1-800-HHS-TIPS
Medicare Beneficiary Help Line	N/A	1-800-MEDICARE (1-800-633-4227) TTY/TDD: 1-877-486-2048
Part 6 - Introduction to HIPAA		
Subject	**Office/Company and Address**	**Phone Number**
Health Insurance Portability and Accountability Act (HIPAA) Hot Line	N/A	1-866-282-0659
Reference B - Form CMS-1500		
Subject	**Office/Company and Address**	**Phone Number**
Government Printing Office (GPO) for Publication Order Inquiries	Superintendent of Documents P.O. Box 371954 Pittsburgh, PA 15250-7954	1-866-512-1800

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