Medicare Claims Processing Manual
Chapter 1 - General Billing Requirements

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01 - Foreword

(Rev. 3086, Issued: 10-03-14, Effective: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012, Implementation ICD-10: Upon Implementation of ICD-10; ASC X12: November 4, 2014)

Generally, this chapter describes policy applicable to Medicare fee-for-service claims, or what is known as the original or traditional Medicare program. See the Medicare Managed Care Manual for services to enrollees in managed care plans.

Unless specified otherwise the instructions in this chapter apply to both providers and suppliers, and to the contractors that process their claims.

In this chapter the terms provider and supplier are used as defined in 42 CFR 400.202.

- Provider means a hospital, a CAH, a skilled nursing facility, a comprehensive outpatient rehabilitation facility, a home health agency, or a hospice that has in effect an agreement to participate in Medicare, or a clinic, a rehabilitation agency, or a public health agency that has in effect a similar agreement but only to furnish outpatient physical therapy or speech-language pathology services, or a community mental health center that has in effect a similar agreement but only to furnish partial hospitalization services.

- Supplier means a physician or other practitioner, or an entity other than a provider that furnishes health care services under Medicare. A supplier must meet certain requirements and enroll as described in Chapter 10 of the Medicare Program Integrity Manual. A provider that meets the applicable conditions may also enroll as a supplier of a particular service and may bill separately for that service where Medicare payment policy allows separate payment for the service.

In this chapter and in subsequent chapters of Pub. 100-04, the terms 'institutional claim' and 'professional claim' are defined by the submission format of the claim.

- Institutional claim means any claim submitted using the Health Insurance Portability and Accountability Act (HIPAA) mandated transaction ASC X12 837 institutional claim or the paper Form CMS-1450.

- Professional claim means any claim submitted using the HIPAA mandated transaction ASC X12 837 professional claim or the CMS-1500 paper claim form.

01.1 – Remittance Advice Coding Used in this Manual

(Rev. 10236, Issued: 07-31-2020, Effective: 08-31-2020, Implementation: 08-31-2020)

When Medicare denies coverage or adjusts the payment amount for items or services, these actions are documented using codes reported on the provider's remittance advice. Medicare, like all other health insurance payers, uses remittance advice codes in combination to create one message. This combination includes a Claim Adjustment

Group Code (Group Code) and a Claim Adjustment Reason Code (CARC). Frequently, payers also use one or more Remittance Advice Remark Codes (RARC) to add additional detail. RARC coding is optional unless the CARC definition requires an accompanying RARC, so RARCs may not appear on all remittance advice messages.

Each of the codes in the message communicates different information:

- Group Codes assign financial responsibility to the provider or the beneficiary
- CARCs communicate the general reason why the payment is different from the billed amount
- RARCs, when used in combination with CARCs, provide additional or more specific payment adjustment information

In certain cases, RARCs may also be used alone to provide information unrelated to the difference between the amount billed and the amount paid. In these cases, the RARC definition always begins with the word "Alert."

Remittance advice codes are identified in standard code sets that are used by all payers, as required by HIPAA. Since the definitions of the codes are an industry standard, the instructions in this manual refer only to the code values. Providers and contractors can access the definitions of the codes at the official Washington Publishing Company website.

Section 1171 of the Social Security Act requires a standard set of operating rules to regulate the health insurance industry's use of electronic data interchange (EDI) transactions. Operating Rule 360: Uniform Use of CARCs and RARCs, regulates the way in which group codes, CARCs and RARCs may be used. The rule requires specific codes which are to be used in combination with one another if one of the named business scenarios applies. This rule is authored by the Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE).

Medicare and all other payers must comply with the CAQH CORE-developed code combinations. The business scenario for each payment adjustment must be defined, if applicable, and a valid code combination selected for all remittance advice messages. Providers and contractors can access the business scenarios and code combinations at: caqh.org/CORECodeCombinations.php. When remittance advice messages are used to explain payments to providers, Medicare Summary Notice (MSN) messages are used to explain payments to beneficiaries.

In order to provide remittance advice codes and MSN messages consistently throughout the Medicare Claims Processing Manual, the one of the following standard language statements will be included as necessary.

- If the CARC/RARC being reported is included in the CAQH CORE list of valid combinations:

  "The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario [Insert Business Scenario number].

  Group Code: [Insert Group Code]
  CARC: [Insert CARC number or N/A if the RARC is an Alert message]
  RARC: [Insert RARC number(s) or N/A if a RARC is not needed]
  MSN: [Insert MSN message number(s)]"

- If the CARC is not included in the CAQH CORE publication and therefore, standard business scenarios do not apply:

  "The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. The CARC below is not included in the CAQH CORE Business Scenarios.

  Group Code: [Insert Group Code]
  CARC: [Insert CARC number or N/A if the RARC is an Alert message]
  RARC: [Insert RARC number(s) or N/A if a RARC is not needed]
  MSN: [Insert MSN message number(s)]"

02.1.1 - HIPAA Standards for Claims

(Rev. 10236, Issued: 07-31-2020, Effective: 08-31-2020, Implementation: 08-31-2020)

The standards adopted under HIPAA include both a transaction standard and an implementation guide. The following are the claims transactions and the implementation guides adopted as standards under HIPAA:

Standard Claim Transaction	Short Reference	Implementation Guide	Type of Claim
ASC X12 Health Care Claim: Professional (837)	ASC X12 837 professional claim	ASC X12 Standards for Electronic Data Interchange Technical Report Type 3—Health Care Claim: Professional (837)	Professional services and supplies, including retail pharmacy
ASC X12 Health Care Claim: Institutional (837)	ASC X12 837 institutional claim	ASC X12 Standards for Electronic Data Interchange Technical Report Type 3—Health Care Claim: Institutional (837)	Institutional

Standard Claim Transaction	Short Reference	Implementation Guide	Type of Claim
Telecommunication Standard, National Council for Prescription Drug Programs and equivalent Batch Standard, National Council for Prescription Drug Programs	Depending upon context: NCPDP claim; NCPDP transaction; NCPDP batch transaction; NCPDP batch claim	Telecommunication Standard Implementation Guide and equivalent Batch Standard Implementation Guide, National Council for Prescription Drug Programs.	Retail pharmacy professional services and supplies; retail pharmacy drugs

Claims sent electronically to Medicare must abide by the HIPAA standards listed above. The current versions of these HIPAA standards are listed in chapter 24 of this manual. More information about HIPAA can be found at www.cms.gov, under the "Regulations and Guidance" tab. More information about these transactions and implementation guides can be found, as appropriate, at the official ASC X12 website and www.NCPDP.org.

In addition, chapter 24 of this manual provides more information regarding Medicare's requirements for electronic data interchange (EDI), such as EDI enrollment and trading partner agreements.

Note that HIPAA standard implementation guides provide comprehensive directions regarding how to submit a claim on the transactions they support. Therefore, there is no separate guidance in this claim processing manual as to how to submit a claim using these transactions. However, there may be situations where the Medicare requirements require additional clarification, description, or guidance. In such cases, there will be additional instructions in the appropriate subject area section.

02 - Formats for Submitting Claims to Medicare

(Rev. 3086, Issued: 10-03-14, Effective: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012, Implementation ICD-10: Upon Implementation of ICD-10; ASC X12: November 4, 2014)

02.1 - Electronic Submission Requirements

(Rev. 10236, Issued: 07-31-2020, Effective: 08-31-2020, Implementation: 08-31-2020)

The standards adopted under HIPAA include both a transaction standard and an implementation guide. The following are the claims transactions and the implementation guides adopted as standards under HIPAA:

Standard Claim Transaction	Short Reference	Implementation Guide	Type of Claim
ASC X12 Health Care Claim: Professional (837)	ASC X12 837 professional claim	ASC X12 Standards for Electronic Data Interchange Technical Report Type 3—	Professional services and supplies, including

Standard Claim Transaction	Short Reference	Implementation Guide	Type of Claim
		Health Care Claim: Professional (837)	retail pharmacy
ASC X12 Health Care Claim: Institutional (837)	ASC X12 837 institutional claim	ASC X12 Standards for Electronic Data Interchange Technical Report Type 3—Health Care Claim: Institutional (837)	Institutional
Telecommunication Standard, National Council for Prescription Drug Programs and equivalent Batch Standard, National Council for Prescription Drug Programs	Depending upon context: NCPDP claim; NCPDP transaction; NCPDP batch transaction; NCPDP batch claim	Telecommunication Standard Implementation Guide and equivalent Batch Standard Implementation Guide, National Council for Prescription Drug Programs.	Retail pharmacy professional services and supplies; retail pharmacy drugs

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02.1.2 - Where to Purchase HIPAA Standard Implementation Guides

(Rev. 10236, Issued: 07-31-2020, Effective: 08-31-2020, Implementation: 08-31-2020)

ASC X12 implementation guides (technical report 3s) may be purchased from the official Washington Publishing Company website. NCPDP implementation guides may be purchased from the NCPDP at www.NCPDP.org

02.2 - Paper Claims

(Rev. 3086, Issued: 10-03-14, Effective: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012, Implementation ICD-10: Upon Implementation of ICD-10; ASC X12: November 4, 2014)

The ASCA law allows for there to be exceptions for which a provider, or other claim submitter, is permitted to send his/her claims to Medicare on paper. Refer to Chapter 24 §§90-90.5.4 for more information regarding ASCA exceptions.

02.2.1 - Paper Formats for Institutional Claims

(Rev. 3086, Issued: 10-03-14, Effective: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012, Implementation ICD-10: Upon Implementation of ICD-10; ASC X12: November 4, 2014)

The required format for submitting institutional claims to Medicare on paper is the CMS-1450 form. Refer to chapter 25 for more information, including how to complete this form. In addition, where needed, additional instruction is provided throughout this manual for submitting paper claims.

02.2.2 - Paper Formats for Professional and Supplier Claims

(Rev. 3086, Issued: 10-03-14, Effective: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012, Implementation ICD-10: Upon Implementation of ICD-10; ASC X12: November 4, 2014)

The required format for submitting professional and supplier claims to Medicare on paper is the CMS-1500 claim form. Refer to chapter 26 for more information, including how to complete this form. In addition, where needed, additional instruction is provided throughout this manual for submitting paper claims.

02.3 - Remittance Advices

(Rev. 3086, Issued: 10-03-14, Effective: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012, Implementation ICD-10: Upon Implementation of ICD-10; ASC X12: November 4, 2014)

Another of the electronic health care transactions for which HIPAA requires the Secretary to adopt a standard is the remittance advice. The standard adopted is the ASC X12 Health Care Claim Payment/Advice (835). The current HIPAA version, including the implementation guide, is listed in Chapter 24. Throughout this manual, you may see references to this standard's short form, "ASC X12 835 remittance advice." More information about this transaction and its implementation guide can be found in chapters 22 and 24.

10 - Jurisdiction for Claims

(Rev. 1, 10-01-03)

In general FIs have jurisdiction for providers and institutional suppliers. Examples of institutional suppliers are renal dialysis facilities, comprehensive outpatient rehabilitation facilities, rural health clinics, and federally qualified health centers. In general, carriers have jurisdiction for physicians and other individual practitioners, and for labs that are not a part of hospital, ambulance suppliers, ASCs, DME suppliers, and IDTFs.

See §§10.1 - 10.2 for more detail.

10.1 - A/B MACs (Part B) and DME MAC Jurisdiction of Requests for Payment

(Rev. 10840; Issued: 06-11-21; Effective: 07-12-21; Implementation: 07-12-21)

B3-3100

A/B MACs (Part B) have jurisdiction for all claims from the following:

- Physicians;
- Other individual practitioners;
- Groups of physicians or practitioners;
- Labs not part of a hospital;
- Ambulance claims submitted by ambulance companies under their own Medicare number (hospitals may operate ambulances as part of the hospital and bill the A/B MAC (Part A);
- Ambulatory surgical centers (ASCs); and
- Independent diagnostic testing facilities (IDTFs).

Durable Medical Equipment Medicare Administrative Contractors (DME MACs) have jurisdiction for claims from the following:

- Nonimplantable durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) (including home use);

- Suppliers of enteral and parenteral products other than to inpatients covered under Part A;

- Oral drugs billed by pharmacies; and

- Method II home dialysis (for dates of service prior to January 1, 2011). Note: Please refer to Section 30.3.8 for information regarding the elimination of Method II home dialysis for dates of service on and after January 1, 2011.

The CMS maintains a list of which HCPCS codes are under DME MAC only jurisdiction or dual DME MAC/Part B MAC jurisdiction and issues updates to DME MACs and A/B MACs (Part B) as needed (Usually quarterly). Any other codes not listed as DME MAC

only or dual DME MAC/Part B MAC jurisdiction shall be A/B MAC (Part B) only jurisdiction.

There are four DME MACs each of which is assigned specific States.

A/B MACs (Part B) typically process Part B fee-for-service claims for services furnished in specific geographic areas (e.g., a State). However, a single A/B MAC (Part B) processes all physician/supplier claims for railroad retirement beneficiaries. (See §10.1.3 for claims for Part B medical services performed outside the U.S. for individuals who reside in the U.S.).

The rules for determining jurisdiction are the same whether a claim is assigned or nonassigned (see §30.3 for assignment rules).

Further information on A/B MACs (Part B) and DME MACs for specific geographic areas is available on the CMS Web site at https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Who-are-the-MACs .

Most skilled nursing facilities submit claims to the A/B MACs (Part A). However, a nonparticipating skilled nursing facility (SNF) is considered a supplier and its claims are submitted to the appropriate A/B MACs (Part B) under its own Medicare supplier number.

10.1.1 - Payment Jurisdiction among A/B MACs (Part B) for Services Paid Under the Physician Fee Schedule and Anesthesia Services

(Rev. 4473, Issued: 12-6-19; Effective: 3-9-20; Implementation: 3-9-20)

The jurisdiction for processing a request for payment for services paid under the Medicare Physician Fee Schedule (MPFS) and for anesthesia services is governed by the payment locality where the service is furnished and will be based on the ZIP code. Though a number of additional services appear on the MPFS database, these payment jurisdiction rules apply only to those services actually paid under the MPFS and to anesthesia services. (For example, it does not apply to clinical lab, ambulance or drug claims.)

Effective for claims received on or after April 1, 2004, A/B MACs (Part B) must use the ZIP code of the location where the service was rendered to determine A/B MACs (Part B) jurisdiction over the claim and the correct payment locality. Effective for dates of service on or after October 1, 2007, except for services provided in POS "Home," if they are not already doing so, A/B MACs (Part B) shall use the CMS ZIP code file along with the ZIP code submitted on the claim with the address that represents where the service was performed to determine the correct payment locality. (See section 10.1.1B for instructions on processing services rendered in POS Home -12 and section 10.1.1.1 for instructions on when a 9-digit ZIP code is required.)

When a physician, practitioner, or supplier furnishes physician fee schedule or anesthesia services in payment localities that span more than one A/B MAC (Part B)'s service area (e.g., provider has separate offices in multiple localities and/or multiple A/B MACs (Part B)), separate claims must be submitted to the appropriate area A/B MACs (Part B) for processing. For example, when a physician with an office in Illinois furnishes services outside the office setting (e.g., home, hospital, SNF visits) and that out-of-office service location is in another A/B MAC (Part B)'s service area (e.g., Indiana), the A/B MAC (Part B) which processes claims for the payment locality where the out of office service was furnished has jurisdiction for that service. It is the A/B MAC (Part B) with the correct physician fee schedule pricing data for the location where the service was furnished. In the majority of cases, the physician fee schedule or anesthesia services provided by physicians are within the same A/B MAC (Part B) jurisdiction that the physicians' office(s) is/are located.

Although pricing rules for services paid under the MPFS remain in effect, effective for claims with dates of service on or after January 25, 2005, suppliers (including laboratories, physicians, and independent diagnostic testing facilities (IDTFs) must bill their A/B MAC (Part B) for the technical component and professional component of diagnostic tests that are subject to the anti-markup payment limitation, regardless of the location where the service was furnished. Beginning in 2005, and in each subsequent calendar year (CY) through 2013, CMS provided A/B MACs (Part B) with a national abstract file containing Healthcare Common Procedural Coding System (HCPCS) codes that are payable under the MPFS as anti-markup tests for the year. In addition, CMS made quarterly updates to the abstract file to add and/or delete codes, as needed, in conjunction with the MPFSDB quarterly updates. Beginning in 2014, CMS adopted a more streamlined approach to providing the A/B MACs with the HCPCS codes payable under the MPFS as anti-markup tests for the year. The national abstract file was discontinued and an Anti-markup (formerly Purchased Diagnostic) Test Indicator, to identify HCPCS codes payable under the MPFS as anti-markup tests for the year, was added to the MPFS payment file. Quarterly updates to the Anti-Markup Test Indicator are made directly to the MPFS Payment file. As with all other services payable under the MPFS, the ZIP code of the locality in which the service was furnished determines the payment amount. Refer to §30.2.9 of this chapter for information on the anti-markup payment limitation as it applies to supplier billing requirements.

A. Multiple Offices

In states with multiple physician fee schedule pricing localities or where a provider has multiple offices located in two or more states, or there is more than one A/B MAC (Part B) servicing a particular state, physicians, suppliers and group practices with multiple offices in such areas must identify the specific location where office-based services were performed. This is to insure correct claim processing jurisdiction and/or correct pricing of MPFS and anesthesia services. The A/B MAC (Part B) must ensure that multiple office situations are cross-referenced within its system. If a physician/group with offices in more than one MPFS pricing locality or a multi-contractor state fails to specify the

location where an office-based service was furnished, the A/B MAC (Part B) will return/reject the claim as unprocessable.

Physicians, suppliers, and group practices that furnish physician fee schedule services at more than one office/practice location may submit their claims through one office to the A/B MAC (Part B) for processing. However, the specific location where the services were furnished must be entered on the claim so the A/B MAC (Part B) has the ZIP code, can determine the correct claims processing jurisdiction, and can apply the correct physician fee schedule amount.

B. Service Provided at a Place of Service Other than Home-12 or Office-11

For claims submitted prior to April 1, 2004, in order to determine claims jurisdiction, Medicare approved charges, Medicare payment amounts, Medicare limiting charges and beneficiary liability, Part B fee-for-service claims for services furnished in other than in an office setting or a beneficiary's home must include information specifying where the service was provided.

Effective for claims received on or after April 1, 2004, claims for services furnished in all places of service other than a beneficiary's home must include information specifying where the service was provided. A/B MACs (Part B) must use the address on the beneficiary files when place of service (POS) is home - 12, or any other mechanism currently in place to determine pricing locality when POS is home – 12. A/B MACs (Part B) shall take this same action for any other POS codes they currently treat as POS home.

Effective for claims processed on or after October 5, 2009, for services rendered in POS home -12, or for any other POS the contractor currently treats as POS home, when alerted by the shared system that a 9-digit ZIP code is required according to the CMS ZIP Code file, and a 9-digit ZIP code is not available on the beneficiary file, the contractor shall determine that ZIP code by using the United States Postal Service Web site. They shall use that ZIP code to determine the correct payment locality for the claim for pricing purposes.

A/B MACs (Part B) processing these claims shall take necessary steps to ensure that the claims for services rendered in the physical location for which they are the MAC are priced and processed correctly applying appropriate edits as necessary.

Effective January 1, 2011, for claims processed on or after January 1, 2011, using the 5010 version of the ASC X12 837 professional claim format, submission of the complete address of where the service was performed is required regardless of where the service was performed. This information should be entered on the claim per the Implementation Guide for the current version. Contractors shall use that ZIP code to determine correct payment locality.

Effective January 1, 2011 for claims processed on or after January 1, 2011 on paper claims submitted on the CMS-1500 form, submission of the ZIP code of where the service was provided will also be required for all POS code and contractors shall use that ZIP code to determine correct payment locality.

For paper and electronic claims, when a global diagnostic service code is billed (e.g. no modifier TC and no modifier 26), the address where the technical component was performed shall be reported on the claim (this only applies to global services with separate technical component/professional component). Global billing does not apply to anti-markup tests because the technical and professional component must be billed separately when the anti-markup payment limitation applies.

Refer to Pub 100-04, Chapter 35, Section 10.2.1 and 10.2.2 for more information on global billing and separate technical and professional billing.

Contractors shall make no changes for claims submitted on the 4010A1 format as they pertain to POS Home and determining pricing locality.

Contractors shall require the submission of the 9-digit ZIP code when required per the CMS ZIP Code file.

C. Outside A/B MAC (Part B) **Jurisdiction**

If A/B MACs (Part B) receive claims outside of their jurisdiction, they must follow resolution procedures in accordance with the instructions in 10.1.9. If they receive a significant volume or experiences repeated incidences of misdirected Medicare Physician Fee Schedule or anesthesia services from a particular provider, an educational contact may be warranted.

D. HMO Claims

For services that HMOs are not required to furnish, A/B MACs (Part B) process claims for items or services provided to an HMO member over which they have jurisdiction in the same manner as they process other Part B claims for items or services provided by physicians or suppliers. Generally, the physician/supplier who provides in-plan services to its HMO members submits a bill directly to the HMO for payment and normally does not get involved in processing the claim. However, in some cases, claims for services to HMO members are also submitted to A/B MACs (Part B), e.g., where claims are received from physicians for dialysis and related services provided through a related dialysis facility.

10.1.1.1 - Claims Processing Instructions for Payment Jurisdiction

(Rev. 4473, Issued: 12-6-19; Effective: 3-9-20; Implementation: 3-9-20)

A. Instructions for the 4010/4010A1 Version of the ASC X12 837 Professional Electronic Claim (for Claims Processed Before Implementation of Version 5010)

Note that the following instructions do not apply to services rendered at POS home -12. For services rendered at POS home – 12, use the address on the beneficiary file for the beneficiary's home (or wherever else the beneficiary information is currently being stored) to determine pricing locality. *(*See §10.1.1 for changes to processing for services rendered at POS home – 12.)

For pricing purpose, contractors shall use the ZIP code of where the service was performed. Contractors shall locate that information according to the Implementation Guide of the 4010/4010A1 version of the ASC X12 837 professional claim format.

EXCEPTION: For DME MAC claims - Effective for claims received on or after 1/1/05, the Standard System shall not evaluate the 2010AA loop for a valid place of service. If there is no entry in the 2420C loop or the 2310D loop, the claim shall be returned as unprocessable.

- If the Pay-To Provider Name and Address loop 2010AB is not the same as the Billing Provider, both will be entered. If the Service Facility Location loop 2310D is not the same as the Billing Provider or the Pay-To Provider, the Service Facility Location loop 2310D (claim level) will be entered. Price the service based on the ZIP code in Service Facility Location loop 2310D, unless the 2420C (line level) is also entered. In that case, price the service based on the ZIP code in the Service Facility Location loop 2420C (line level) for that line.

If the POS code is the same for all services, but the services were provided at different addresses, each service shall be submitted with the appropriate address information for each service. This will provide a ZIP code to price each service on the claim.

B. Entering the Address of Where a Service was Performed on the 5010 Version of the ASC X12 837 Professional Claim

Following the requirements of the implementation guide of the 5010 version of the ASC X12 837professional claim, the complete address of where a service was performed shall be entered. Pay the service based on the ZIP code of the address of where the service was performed based on the appropriate entry on the claim.

See §30.2.9 and Chapter 12 for information on anti-markup tests.

C. Paper Claims Submitted on the Form CMS-1500

Note that for claims processed on the Form CMS-1500 prior to January 1, 2011, the following instructions do not apply to services rendered at POS home – 12 or any other places of service contractors consider to be home. (See §10.1.1.1)

It is acceptable for claims to contain POS home and an additional POS code. No service address for POS home needs to be entered for the service rendered at POS home in this

situation as the address will be drawn from the beneficiary file (or wherever else the A/B MAC (Part B) is currently storing the beneficiary information) and the information on the claim will apply to the other POS.

Except for the situation described above, the provider shall submit separate claims for each POS. The specific location where the services were furnished shall be entered on the claim. Use the ZIP code of the address entered in Item 32 to price the claim. If multiple POS codes are submitted on the same claim, treat the claim as unprocessable and follow the instructions in §80.3.1.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.

Group Code: CO
CARC: 16
RARC: M77
MSN: 9.2

Effective January 1, 2011, for claims processed on or after January 1, 2011, submitted on the Form CMS-1500 paper claim, it will no longer be acceptable for the claim to have more than one POS. Separate claims must be submitted for each POS. Contractors shall treat claims submitted with more than one POS as unprocessable and follow the instructions in §80.3.2.1.1.

If the contractor receives a fee-for-service claim containing one or more services for which the MPFS payment locality is in another A/B MAC (Part B)'s jurisdiction, handle in accordance with the instructions in §10.1.9. If you receive a significant volume or experience repeated incidences of misdirected Medicare Physician Fee Schedule claims/services from a particular provider, an educational contact may be warranted. Handle misdirected claims/services for HMO enrollees in accordance with §10.1.1.C and D.

D. Determining the Correct Payment Locality for Services Paid Under the Medicare Physician Fee Schedule (MPFS) and Anesthesia Services When Rendered in a Payment Locality that Crosses ZIP Code Areas

Per the instructions above, Medicare A/B MACs (Part B) have been directed to determine the payment locality for services paid under the MPFS and anesthesia services by using the ZIP code on the claim of where the service was performed. It has come to the attention of CMS that some ZIP codes fall into more than one payment locality. The CMS ZIP Code file uses the convention of the United States Postal Service, which assigns these ZIP codes into dominant counties. In some cases, though the service may actually be rendered in one county, per the ZIP code it is assigned into a different county. This causes a payment issue when each of the counties has a different payment locality and therefore a different payment amount. Note that as the for services which have the

Anti-markup Test Indicator on the MPFS, the 9-digit ZIP code requirements will also apply to those codes.

Effective for dates of service on or after October 1, 2007, CMS shall provide a list of the ZIP codes that cross localities as well as provide quarterly updates when necessary. The CMS ZIP Code file shall be revised to two files: one for 5-digit ZIP codes (ZIP5) and one for 9-digit ZIP codes (ZIP9). Providers performing services paid under the MPFS, anesthesia services, or any other services as described above, in those ZIP codes that cross payment localities shall be required to submit the 9-digit ZIP codes on the claim for where the service was rendered. Claims for services payable under the MPFS and anesthesia services that are NOT performed in one of the ZIP code areas that cross localities may continue to be submitted with 5-digit ZIP codes. Claims for services other than those payable under the MPFS or anesthesia services may continue to be submitted with 5-digit ZIP codes.

Beginning in 2009, contractors shall maintain separate ZIP code files for each year which will be updated on a quarterly basis. Claims shall be processed using the correct ZIP code file based on the date of service submitted on the claim.

It should be noted that though some states consist of a single pricing locality, ZIP codes can overlap states thus necessitating the submission of the 9-digit ZIP code in order to allow the process to identify the correct pricing locality.

Claims received with a 5-digit ZIP code that is one of the ZIP codes that cross localities and therefore requires a 9-digit ZIP code to be processed shall be treated as unprocessable.

For claims received that require a 9-digit ZIP code with a 4-digit extension that does not match a 4-digit extension on file, manually verify the 4-digit extension to identify a potential coding error on the claim or a new 4-digit extension established by the U.S. Postal Service (USPS). ZIP code and county information may be found at the USPS Web site at http://www.usps.com/, or other commercially available sources of ZIP code information may be consulted. If this process validates the ZIP code, the claim may be processed. The "Revision to Payment Policies under the Physician Fee Schedule" that is published annually in the Federal Register, or any other available resource, may be used to determine the appropriate payment locality for the ZIP code with the new 4-digit extension. If this process does not validate the ZIP code, the claim shall be treated as unprocessable.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.

Group Code: CO
CARC: 16
RARC: MA114

MSN: N/A

Should a service be performed in a ZIP code area that does not require the submission of the 9-digit ZIP code, but the 4-digit extension has been included anyway, A/B MACs (Part B) shall price the claim using the A/B MAC (Part B) locality on the ZIP5 file and ignore the 4-digit extension.

Effective for claims processed on or after July 6, 2009, the standard system shall make revisions to allow contractors to add valid 4-digit extensions not included on the current quarter's 9-digit ZIP Code file until they appear on a quarterly file.

Contractors shall reprocess claims brought to their attention if the next CMS quarterly file is received and the locality determination on a new 4-digit extension is different than that made manually by the contractor thus having inadvertently caused incorrect payment.

E. ZIP9 Code to Locality Record Layout

Below is the ZIP9 Code to locality file layout. Information on the naming conventions, availability, how to download the ZIP5 and ZIP9 files, and the ZIP5 layout can be found in Pub. 100-04, Chapter 15, section 20.1.6.

ZIP9 Code to Locality Record Layout
(Effective for dates of service on or after October 1, 2007.)

Field Name	Beg. Position	End Position	Length	Comments
State	1	2	2	
ZIP Code	3	7	5	
A/B MAC (B)	8	12	5	
Pricing Locality	13	14	2	
Rural Indicator	15	15	1	Blank=urban R=rural B=super rural
Filler	16	20	5	
Plus Four Flag	21	21	1	0=no+4 extension 1=+4 extension
Plus Four	22	25	4	

10.1.1.2 - Payment Jurisdiction for Services Subject to the Anti-Markup Payment Limitation

(Rev. 4473, Issued: 12-6-19; Effective: 3-9-20; Implementation: 3-9-20)

Diagnostic tests and their interpretations are paid on the MPFS. Therefore, they are subject to the same payment rules as all other services paid on the MPFS. Additional explanation is provided here due to general confusion concerning these services when they are performed or supervised by a physician or other supplier who does not meet the criteria for "sharing a practice" with the billing physician or other supplier, rather than rendered and billed by the billing entity. (See §30.2.9 for additional information on "sharing a practice.") Physicians and other suppliers must meet the current enrollment criteria stated in chapter 15, of the Program Integrity Manual, in order to be able to bill for anti-markup tests. That these services are billed by an entity that does not share a practice with the performing physician or other supplier does not negate the need for the performing physician or other supplier to follow appropriate enrollment procedures with the A/B MAC (Part B) that has jurisdiction over the geographic area where the services were rendered.

The A/B MAC (Part B) must accept and process claims for services subject to the anti-markup payment limitation when billed by physicians or other suppliers enrolled in the A/B MAC (Part B)'s jurisdiction, regardless of the location where the services were furnished.

Effective for claims processed on or after April 1, 2004, in order to allow the A/B MAC (Part B) to determine jurisdiction and apply the anti-markup payment limitation correctly, global billing will not be accepted on electronic or paper claims when billing anti-markup tests. Claims received with global billings in this situation will be treated as unprocessable per §80.3.

Effective for claims submitted with a receipt date on and after October 1, 2015, billing physicians and suppliers must report the name, address, and NPI of the performing physician or supplier on all anti-markup and reference laboratory claims, even if the performing physician or supplier is enrolled in a different contractor's jurisdiction. Contractors shall return as unprocessable any anti-markup or reference laboratory claim with an NPI in Item 32a (or its electronic equivalent) that belongs to the billing physician/supplier, or that cannot be verified as a valid, Medicare enrolled entity.

A. Payment Jurisdiction for Suppliers of Diagnostic Tests and Interpretations Performed by Other Suppliers under Contract

Effective for claims with dates of service on or after January 25, 2005, laboratories, physicians, and IDTFs must submit all claims for anti-markup tests to their local A/B MAC (Part B). A/B MAC (Part B) must accept and process claims for services subject to the anti-markup payment limitation when billed by suppliers enrolled in the A/B MAC (Part B) jurisdiction, regardless of the location where the services were furnished. A/B MAC (Part B) should allow claims submitted by an IDTF for anti-markup tests if the IDTF has previously enrolled to bill for anti-markup test components they perform.

Effective April 1, 2005, A/B MAC (Part B) must price anti-markup tests billed by laboratories and IDTF's based on the ZIP code of the location where the diagnostic test was rendered.

Effective for claims with dates of service on or after October 1, 2007 through 2013, A/B MAC (Part B) must use the national abstract file to price all claims for anti-markup tests for all supplier specialty types (including physicians), based on the ZIP code of the location where the service was rendered. Beginning in 2014, A/B MAC (Part B) must refer to an Anti-markup Test Indicator, to identify HCPCS codes payable under the MPFS as anti-markup tests for the year.

10.1.1.3 - Payment Jurisdiction for Reassigned Services

(Rev. 1987, Issued: 06-11-10, Effective: 08-12-10, Implementation: 08-12-10)

Though a supplier or provider may reassign payment for his services to another entity, suppliers are still required to bill the correct B/MAC for reassigned services when they are paid under the MPFS. The billing entity must submit claims to the B/MAC that has jurisdiction over the geographic area where the services were rendered. Suppliers and providers must also meet current enrollment criteria stated in chapter 10 of the Program Integrity Manual in order to be able to bill for reassigned services.

10.1.3 - Exceptions to Jurisdictional Payment

(Rev. 1, 10-01-03)
B3-3100.6, R1813B3

Exceptions to billing the area carrier are:

- A claim for covered services performed in the United States by a legally authorized Canadian or Mexican physician is within the jurisdiction of the carrier servicing the location where the services were rendered.

- Because coverage of Part B services furnished in Canada or Mexico is contingent upon coverage of related inpatient hospital services, carriers designated to process foreign claims identified in §10.1.4.2 will receive such claims from the FI servicing the foreign hospital only after the FI has determined that the Part A services are covered. (If the request is for payment of medical services performed outside the United States by a physician or supplier whose office is located in the United States, the carrier servicing the physician's or supplier's office has jurisdiction. This carrier issues the denial determination and handles any resultant appeal.)

- If a claim by an individual who resides outside the United States involves both medical services performed within the United States and medical services performed outside the United States the carrier will process both segments of the claim.

10.1.5 - Domestic Claims Processing Jurisdictions
(Rev. 1, 10-01-03)
B3-3102, B3-3116

10.1.5.1 - Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, Supplies, Parental and Enteral Nutrition (PEN)
(Rev. 2487, Issued: 06-08-12, Effective: 01-01-11, Implementation: 06-19-12)

B3-3116, B-3102

Claims for DMEPOS submitted by suppliers for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) are handled by Durable Medical Equipment Medicare Administrative Contractors (DME MACs).

To determine which services are processed by DME MACs vs. local carriers, CMS maintains and updates a table of services by HCPCS code that indicates who to bill for which services. The CMS updates this list by a special One-Time Special Notification as needed. In general, claims for DMEPOS, other than implanted durable medical equipment and implanted prosthetic devices, are processed by the appropriate DME MAC. The appropriate A/B MAC processes claims for implanted durable medical equipment and implanted prosthetic devices, as well as DMEPOS items incident to a physician's service.

Note that **surgical procedures** for implantable DME or for prosthetic devices, performed in an inpatient or outpatient hospital setting include the cost of the device in the Diagnosis Related Group (DRG) or Ambulatory Payment Classification (APC) rate. However, there are some implantable devices that are eligible for separate pass through under Outpatient Prospective Payment System (OPPS). DME MACs do not process claims for DMEPOS items that are subject to consolidated billing or bundled payment under Prospective Payment System (PPS) or in a DRG.

Claims from parenteral and enteral nutrition (PEN) suppliers are processed by the DME MAC.

Method II ESRD claims for dates of service prior to January 1, 2011, are also processed by the DME MAC. For dates of service on and after January 1, 2011, refer to Section 30.3.8 for information regarding the elimination of Method II home dialysis.

The claims processing jurisdiction among DME MACs is determined by the beneficiary's permanent address. A beneficiary's permanent address is determined by where the beneficiary resides for more than six months of a year. See the CMS Web site at http://www.cms.hhs.gov/contacts/incardir.asp for a list of State jurisdictions by DME MAC.

10.1.5.2 - Supplier of Portable X-Ray, EKG, or Similar Portable Services

(Rev. 1, 10-01-03)

If a supplier operates mobile units in geographic areas served by more than one carrier, the carrier serving the area where the service was performed must process the claims.

10.1.5.3 - Ambulance Services Submitted to Carriers
(Rev. 1, 10-01-03)

Jurisdiction of the claim is based on whether only one ambulance vehicle or multiple vehicles were used.

A. One Ambulance Vehicle Used

If only one vehicle is used to transport the patient from the point of initial pickup to the final destination, jurisdiction is with the carrier serving the point of origin, i.e., home station of the vehicle. This carrier has qualification information on the ambulance supplier and in most cases all other pertinent details necessary to adjudicate a claim.

EXAMPLE: A patient is picked up at the Johns Hopkins Hospital in Baltimore, Maryland and transported to his home in West Virginia by an ambulance dispatched from the area of the patient's home. The carrier serving the point of origin of the ambulance, Nationwide Mutual Insurance Company, Part B carrier for the State of West Virginia, has jurisdiction of any claim filed. In this case Nationwide should have all the data necessary to make proper payment, i.e., certification of the ambulance company, price information and data pertaining to the nearest appropriate company, price information and data pertaining to the nearest appropriate facility. Had an ambulance whose home station was in Baltimore been used, the carrier servicing Baltimore, Maryland would have had jurisdiction. The Baltimore carrier would then have had to obtain data concerning the nearest appropriate facility to the patient's home from Nationwide

B. More Than One Vehicle Used

If more than one vehicle is used in transporting the patient to their destination, jurisdiction of the claim lies with:

- The carrier serving the home base of the ambulance taking the patient on the **first leg of the trip**, on a trip **to** a distant institution more remote than the nearest appropriate facility; or

- The carrier serving the home base of the ambulance taking the patient on the **final leg** of the trip home, on a trip **from** an institution more remote than the nearest appropriate facility.

- If there is **no** claim for the final leg of the trip, the carrier serving the patient's home area handles any resulting claims or disallowance actions.

EXAMPLE: A patient is transported by ambulance from a hospital in Miami Beach, Florida to Miami International Airport and from there by air ambulance to LaGuardia Airport in Queens, New York City. At the airport he is picked up by an ambulance (based in Yonkers, New York) and taken to his home in Yonkers, New York. The carrier that handles the adjudication is the carrier whose area of responsibility includes Yonkers, New York, since partial reimbursement is based upon the nearest appropriate facility to his residence when he is being returned home from a distant institution.

In rules A and B above, the principle followed is that the carrier having the information to determine the "nearest appropriate facility" is the one to adjudicate the claim. In any event, before **any** partial reimbursement can be made, the carriers as designated in rules A and B, must have all the information concerning the patient's transportation, **from initial pickup to final destination**.

10.1.5.4 - Independent Laboratories
(Rev. 1, 10-01-03)

Jurisdiction of claims for laboratory services furnished by an independent laboratory normally lies with the carrier serving the area in which the laboratory test is performed. However, there are some situations where a regional or national lab chain jurisdiction is with a single carrier.

10.1.5.4.1 - Cases Involving Referral Laboratory Services
(Rev. 1, 10-01-03)

If the specimen is drawn or received by an independent laboratory approved under the Medicare program that performs a covered test, but the lab refers the specimen to another laboratory in a different carrier jurisdiction for additional tests, the carrier servicing the referring laboratory retains jurisdiction for services performed by the other laboratory.

Examples of Independent Laboratory Jurisdiction

EXAMPLE 1:

An independent laboratory located in Oregon performs laboratory services for physicians whose offices are located in several neighboring States. A physician from Nevada sends specimens to the Oregon laboratory. If the laboratory sends the results to the physician and accepts assignment, the carrier in Oregon has jurisdiction.

EXAMPLE 2:

American Laboratories, Inc., is an independent laboratory company with branch laboratories located in Philadelphia, Pennsylvania, and Wilmington, Delaware, as well as regional laboratories located in Millville, New Jersey, and Boston, Massachusetts.

The Philadelphia laboratory receives a blood sample from a patient whose physician ordered a complete blood count, an SMAC T-4, and a B12 and folate. The Philadelphia lab performs the complete blood count, but the SMAC T-4 is performed at the Millville lab, while the B12 and folate is performed at the Boston Lab. The Pennsylvania carrier retains jurisdiction for processing the claims **if they have certification information and the appropriate fee schedule allowance in house**. Otherwise, the local carrier servicing Boston and/or Millville has jurisdiction for processing their claims.

The Wilmington laboratory draws a blood specimen from a patient whose physician has ordered a blood culture. The Wilmington lab then sends the specimen to the Boston laboratory, which performs the required test. American Laboratories accepts an assignment for the service.

If the Delaware carrier has the capability of comparing the Wilmington lab's charge for the blood culture against the appropriate reasonable charge screens for the Boston lab, the Delaware carrier will retain jurisdiction for processing the claim. If the Delaware carrier does not have this capability, the claim should be transferred to the Massachusetts carrier for processing.

10.1.6 - Railroad Retirement Beneficiary Carrier

(Rev. 142, 04-16-04)
B3-3103

Carrier jurisdiction claims for individuals who are QRRBs, including those who are entitled to both social security and railroad retirement benefits, are handled by the Palmetto Government Benefits Administrators (GBA) LLC, a subsidiary of Blue Cross and Blue Shield of South Carolina, with the following exceptions:

- The services are furnished by a M+C organization which deals directly with CMS on a cost basis;

- The QRRB is enrolled under a buy-in agreement involving a State agency that has entered into an agreement to act as a carrier with respect to such individuals; or;

- The medical services were provided outside the United States, in which case the RRB handles the claim. (See §10.1.4.6 for handling claims for services in Mexico.)

If a claim involves medical services provided both within and outside the United States, Palmetto GBA processes the claim for the medical services provided within the United States. If the claimant raises a question as to why the medical services provided outside the United States were not paid, Palmetto GBA directs the claimant to contact the RRB and forwards the claims to them at:

Railroad Retirement Board
Division of Disability and Health Insurance

844 Rush St.
Chicago, IL 60611

10.1.7 - Welfare Carriers

(Rev. 1, 10-01-03)
B3-3104, B3-3060 for buy-in definition

Section 1843(f) of Title XVIII permits a State agency that administers a plan under Titles I, XVI, or XIX to become the carrier for individuals enrolled in the State's Buy In agreement. Currently there are no State agencies that are serving as carriers.

10.1.9 - Disposition of Misdirected Claims to the B/MAC/Carrier/DME MAC

(Rev. 2474, Issued: 05-18-12, Effective: 07-20-12, Implementation;-7-20-12)

A "misdirected claim" is a claim that has been submitted to the wrong place. This section summarizes the disposition of misdirected claims by B MACs, carriers, and DME MACs.

Each fee-for-service claims administration contractor is assigned a specific geographic and subject matter jurisdiction for claims processing. Physicians and other suppliers are required to submit claims to the contractor having the appropriate jurisdiction. Jurisdictional rules are specified in this Chapter at Section 10.

A contractor may not knowingly adjudicate a misdirected claim and, as such, upon receipt of such a claim, must dispose of the claim in accordance with the specifications of this section or other relevant instructions.

This section addresses the following types of misdirected claims:

1. a CMS-1500 or electronic claim submitted to the wrong local contractor (Part B MAC or carrier);

2. a CMS-1500 or electronic claim submitted to a local contractor (Part B MAC or carrier) that should have been submitted to a DME MAC;

3. a CMS-1500 or electronic claim submitted to a DME MAC that should have been submitted to a local contractor (Part B MAC or carrier);

4. a CMS-1500 or electronic claim submitted to a local contractor (Part B MAC or carrier) that should have been submitted to the Railroad Retirement Board (RRB);

5. a CMS-1500 or electronic claim submitted to a DME MAC or a local contractor (Part B MAC or carrier) that should have been submitted the United Mine Workers of America (UMWA);

6. a CMS-1500 claim that should be submitted to a DME MAC that is submitted to the wrong DME MAC, and

This subsection does not apply to:

1. misdirected beneficiary-submitted claims. See Section 80.3.2 of this Chapter regarding handling of such claims;

2. electronic claims for durable medical equipment, prosthetics, orthotics, or supplies (DMEPOS) that are submitted to the incorrect DME MAC (misdirected DMEPOS claims are automatically routed to the appropriate DME MAC jurisdiction for processing);

3. a claim submitted to the wrong Part A MAC or fiscal intermediary (FI), including a regional home health intermediary (RHHI).

10.1.9.1 – An A/B MAC (B) Receives a Claim for Services that are in Another A/B MAC (B)'s Payment Jurisdiction

(Rev. 3510, Issued: 04-29-16, Effective: 10-01-16, Implementation; 10-03-16)

When a local contractor (Part B MAC or carrier) receives a CMS-1500 or electronic claim for Medicare payment for items/services furnished outside of its payment jurisdiction, the claim shall be returned as unprocessable.

NOTE: This instruction also applies to claims for DMEPOS items/services that are appropriately billed to the B MAC/carrier, but are billed to the wrong B MAC/carrier payment jurisdiction.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: CO
CARC: 109
RARC: N104
MSN: N/A

10.1.9.2 - An A/B MAC (B) Receives a Claim for Services that are in a DME MAC's Payment Jurisdiction

(Rev. 3510, Issued: 04-29-16, Effective: 10-01-16, Implementation; 10-03-16)

When a local contractor (Part B MAC or carrier) receives a CMS-1500 or electronic claim for Medicare payment for items/services that are in a DME MAC's payment jurisdiction, the claim shall be returned as unprocessable.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: CO
CARC: 109
RARC: N104
MSN: N/A

10.1.9.3 - A DME MAC Receives a Claim for Services that are in an A/B MAC (B)'s Payment Jurisdiction

(Rev. 3510, Issued: 04-29-16, Effective: 10-01-16, Implementation; 10-03-16)

When a local DME MAC receives a CMS-1500 or electronic claim for Medicare payment for items/services that are in a Part B MAC or carrier's payment jurisdiction, the claim shall be returned as unprocessable.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: CO
CARC: 109
RARC: N104
MSN: N/A

10.1.9.4 - An A/B MAC (B) Receives a Claim for an RRB Beneficiary

(Rev. 3510, Issued: 04-29-16, Effective: 10-01-16, Implementation; 10-03-16)

When a local contractor (Part B MAC or carrier) receives a Form CMS-1500 or electronic claim that is identified as a RRB claim for Medicare payment that should be processed by the RRB contractor, the claim shall be returned as unprocessable.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: CO
CARC: 109
RARC: N105
MSN: N/A

NOTE: CMS requests that when RRB receives a claim that is not for an RRB beneficiary that they return the claim to the sender and notify them that the claim must be submitted to the local contractor (Part B MAC or carrier) or DME MAC for processing.

10.1.9.5 - An A/B MAC (B) or DME MAC Receives a Claim for a UMWA Beneficiary

(Rev. 3510, Issued: 04-29-16, Effective: 10-01-16, Implementation; 10-03-16)

When a local contractor (Part B MAC or carrier/DME MAC) receives a Form CMS-1500 or electronic claim that is identified as a UMWA claim for Medicare payment that should be processed by the UMWA, the claim shall be returned as unprocessable.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: CO
CARC: 109
RARC: N127
MSN: N/A

10.1.9.6 - Medicare Carrier or RRB-Named Carrier to Welfare Carrier

(Rev. 2474, Issued: 05-18-12, Effective: 07-20-12, Implementation;-7-20-12)

When a Medicare carrier or RRB-named carrier receives a query reply from CMS that includes a disposition code 46 and a welfare administration carrier number, it transfers the claim to the welfare carrier and notifies the beneficiary. Any pertinent information received or developed is transferred with the claim.

This occurs only if there is a State welfare carrier and the individual is identified in the beneficiary master record as a State buy-in enrollee for that State. For more information on the definition of a welfare carrier, refer to Pub. 100-04, Chapter 1, section 10.1.7.

10.1.9.7 - Protests Concerning Transfer of Requests for Payment to Carrier

(Rev. 2474, Issued: 05-18-12, Effective: 07-20-12, Implementation;-7-20-12)

If Palmetto GBA receives a protest concerning the transfer of a request for Medicare payment to the carrier, the protest, including pertinent name and claim number(s) information, is forwarded to:

Railroad Retirement Board
Medicare Section
844 Rush Street
Chicago, IL 60611

10.1.9.8 - Transfer of Claims Material Between Carrier and Intermediary (FI)

(Rev. 2474, Issued: 05-18-12, Effective: 07-20-12, Implementation;-7-20-12)

If a beneficiary erroneously submits a Form CMS-1490 (beneficiary-filed claim form) to a carrier with an itemized bill for services that must be paid by the FI, the carrier forwards such claims to the FI for the necessary action. The FI will inform the provider to submit a claim once the information is received from the carrier.

If the claim covers a combination of services both within and outside the carrier's jurisdiction the carrier should retain the Form CMS-1490 and any claims material needed for processing and forward a photocopy of the Form CMS-1490 and other claims materials to the other involved carrier(s) or FI(s). The carrier should notify the beneficiary when it transfers the claim.

The patient's signature on the Form CMS-1490 satisfied the signature requirement and protects the filing date for the provider billings. (See §70.1 for time limitations for filing claims).

10.1.9.9 - A DME MAC receives a Paper Claim with Items or Services that are in Another DME MAC's Payment Jurisdiction
(Rev. 3510, Issued: 04-29-16, Effective: 10-01-16, Implementation; 10-03-16)

When a DME MAC receives a claim submitted on the Form CMS-1500 for Medicare payment that should be processed by a DME MAC but was sent to the wrong DME MAC, the claim shall be returned as unprocessable.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: CO
CARC: 109
RARC: N104
MSN: N/A

DME MACs shall continue to follow existing procedures for misdirected beneficiary-submitted claims and electronic claims.

10.2 - FI Jurisdiction of Requests for Payment
(Rev. 1, 10-01-03)

The FIs have jurisdiction for the following:

- All Part A services (hospital, SNF, HHA, and hospice);
- Most Part B services from providers that furnish Part A services; and

- Part B facility services from CORFs, Renal; Dialysis Facilities, Rural Health Clinics, Religious Nonmedical Institutions, Outpatient Physical Therapy Centers, Federally Qualified Health Centers, and Community Mental Health Centers. For example, rural health clinics may bill physician services to carriers under applicable physician provider numbers on carrier-compliant claim formats. Also, some DMEPOS may be billed by home health agencies on claims sent to RHHIs, and some physician, lab and ambulance services may be billed by some types of providers submitting claims to FIs.

Within this general framework, specific jurisdiction among FIs is determined by which FI has received the official tie-in notice from the CMS RO. See §20 for procedures for provider nomination of its FI. Once an FI is assigned, that FI has jurisdiction for all services furnished by the provider or supplier, except those service outside the provider/suppliers scope of service. See the Medicare Claims Processing Manual chapters relating to the service for a description of who may bill the individual service, e.g. lab (Chapter 17) or DME (Chapter 20).

The RHHIs have jurisdiction for HHA and Hospice claims.

There is a national single FI for FQHCs. United Government Systems processes all claims from independent FQHCs.

Regional RHC FIs have jurisdiction for claims from freestanding RHCs. See http://www.cms.hhs.gov/contacts/incardir.asp for a listing of RHC regional FIs. The host provider's area FI has jurisdiction for provider based RHCs and FQHCs.

In addition some provider chains may elect a single FI for all providers in the chain.

A complete list of FIs and carriers and their service areas may be viewed at: http://www.cms.hhs.gov/contacts/incardir.asp.

Note that some providers and supplier under FI claims jurisdiction may also provide covered services outside the scope of the facility service, and may bill these services to the carrier.

Claims sent to the incorrect FI are returned to the provider with an instruction to bill the correct FI.

10.2.1 - FI Payment for Emergency and Foreign Hospital Services
(Rev. 1, 10-01-03)

A. Beneficiary Services Outside United States - Emergency Hospital Admissions

See chapter 3, for detailed information concerning beneficiary services outside the United States. Generally, payment is made for emergency inpatient hospital services in qualified Canadian or Mexican hospitals in the following circumstances:

- A Medicare beneficiary is in the United States when an emergency occurs, and a Canadian or Mexican hospital is closer to, or more accessible from, the site of the emergency than the nearest adequately equipped United States hospital that can provide emergency services, or

- The emergency occurred in Canada while the beneficiary is traveling between Alaska and another State without unreasonable delay and by the most direct route, and a Canadian hospital is closer to, or more accessible from, the site of the emergency than the nearest United States hospital. For this purpose, an emergency occurring within the Canadian inland waterway between the States of Washington and Alaska is considered to have occurred in Canada.

The term "United States" means the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, Northern Mariana Islands, American Samoa and, for purposes of services furnished on a ship, the territorial waters adjoining the land areas of the U.S.

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

B. Nonemergency Inpatient Services Furnished in Foreign Hospitals

If the beneficiary resides in the United States, and a Canadian or Mexican hospital is closer to, or more accessible from, the beneficiary's home than the nearest adequately equipped United States hospital, Medicare will pay for covered services regardless of whether an emergency exists. Residence means the place in the U.S. where a person has a fixed and permanent home to which he intends to return whenever he is away. At the time such services are furnished, the Canadian or Mexican hospital must be accredited by the JCAH or by a hospital approval program of the country in which it is located having standards essentially equivalent to those of the JCAHO.

10.3 - Payments Under Part B for Services Furnished by Suppliers of Services to Patients of a Provider

(Rev. 1, 10-01-03)
B3-3115

Section 1861(w)(1) of the Act permits a hospital, critical access hospital, skilled nursing facility, home health agency, or hospice to obtain under arrangement, services for which an individual is entitled to under Medicare. Doing so discharges the liability of such individual or any other person to pay for the services. This is required in specified situations where the provider is paid under a PPS system.

Examples of this include:

- While a patient is under a home health plan of care, the HHA must provide all covered and medically reasonable home health services and certain supplies (subject to consolidated billing) either directly or under arrangement.

- Where a patient is a SNF inpatient, the SNF must furnish all services within the scope of the SNH benefit.

- Where a patient is a hospital inpatient, the hospital must furnish certain inpatient services.

- Certain services are considered included in the rural health clinic or federally funded health clinic visit.

In such cases, the supplier must look to the provider for payment and the provider will bill the FI.

In some cases, the hospital, SNF, or HHA may also choose not to arrange for additional services in this and bill for them. In some cases the provider may instead arrange for the supplier to furnish the test and to bill the carrier. The provider may make different arrangements with different suppliers. For example a provider may arrange with a lab supplier for the lab to bill for all outpatient lab services and make arrangements with an x-ray supplier for the provider to bill for all x ray services to inpatients and outpatients.

Similarly the supplier may make different arrangements for services to beneficiaries for whom only Part B benefits are payable, from arrangements for beneficiaries for whom Part A benefits are payable under a PPS system.

The FIs notify carriers of contracts that the hospital, critical access hospital, skilled nursing facility, home health agency, or hospice have reported with their suppliers. The carrier should confirm the supplier's understanding of the arrangements to assure that the supplier does not bill inappropriately.

A description of basic services for each benefit type is in the Medicare Benefit Policy Manual and also in the Medicare Claims Processing Manual chapter specific to the provider.

10.4 – Claims Submitted for Items or Services Furnished to Medicare Beneficiaries in State or Local Custody Under a Penal Authority

(Rev. 13272; Issued: 06-18-25; Effective: 01-01-25; Implementation: 05-01-25)

Individuals in custody of a penal authority generally have the status of public charges and, as such, have no obligation to pay for the medical care they receive. The special condition at 42 CFR § 411.4(b) for services furnished to individuals in custody of penal authorities operates as a rebuttable presumption. The presumption is that individuals who are in custody, as the term is described in 42 CFR § 411.4(b), have no legal obligation to pay for health care items or services they receive while in custody; therefore, Medicare is

prohibited from paying for such health care items or services under the no legal obligation to pay payment exclusion. The presumption can be rebutted by a showing that: (1) the State or local government requires individuals in custody to repay the cost of the medical services they receive while in custody; and (2) the State or local government enforces the requirement to pay by billing all such individuals, whether or not covered by Medicare or any other health insurance, and by pursuing collection of the amounts they owe in the same way and with the same vigor that it pursues the collection of other debts.

NOTE: The A/B MAC (A), (B), or (HHH), or DME MAC will require evidence that routine collection efforts include the filing of lawsuits to obtain liens against individuals' assets outside the prison and income derived from non-prison sources.

- The State or local entity documents its case with copies of regulations, manual instructions, directives, etc., spelling out the rules and procedures for billing and collecting amounts paid for prisoners' medical expenses. The A/B MAC (A), (B), or (HHH), or DME MAC will inspect a representative sample of cases in which prisoners have been billed and payment pursued, randomly selected from both Medicare and non-Medicare eligible. The existence of cases in which the State or local entity did not actually pursue collection, even though there is no indication that the effort would have been unproductive, indicates that the requirement to pay is not enforced.

The CMS maintains a file of beneficiaries in custody of a penal authority, obtained from SSA, that is used to edit claims. Specifically, the data contain the names of the Medicare beneficiaries and time periods when the beneficiary is in such Federal, State, or local custody. These data will be compared to the data on the incoming claims. CWF will reject claims where the dates from the SSA file and the dates of service on the claim overlap. Any claims rejected by CWF will contain a trailer to the Medicare contractor indicating the date span covered. Contractors will, in turn, deny payment of such claims.

Providers and suppliers that render items and services to individuals in custody of a penal authority in a jurisdiction that meets the conditions of 42 CFR § 411.4(b)(1)(i) through (iii) should indicate the requirements have been met for payment with the use of a modifier QJ (for A/B MAC (B) or DME MAC processed claims or for outpatient claims processed by A/B MAC (A). Otherwise, the claims are denied.

The regulation at 42 CFR § 411.4(b) states:

"(b) Special conditions for payment for items or services furnished to an individual in the custody of a penal authority.
(1) An individual in the custody of a penal authority is considered to have a legal obligation to pay for items or services furnished to the individual only if the following conditions are met:
(i) State or local law requires the individual to pay the cost of items and services that the individual receives;

(ii) The penal authority enforces the requirement to pay for items or services by billing all individuals who receive such items or services, whether or not covered by Medicare or any other health insurance; and
(iii) The penal authority pursues collection of amounts owed for items or services received in the same way and with the same vigor that it pursues the collection of other debts.
(2) For purposes of this paragraph, a penal authority means a police department or other law enforcement agency, a government agency operating under a penal statute, or a State, local or Federal jail, prison, penitentiary, or similar institution.
(3) For purposes of this paragraph—
(i) an individual is considered to be in the custody of a penal authority if the individual is:
(A) Incarcerated in a jail, prison, penitentiary, or similar institution;
(B) Temporarily outside of a jail, prison, penitentiary, or similar institution on medical furlough or similar arrangement;
(C) Escaped from confinement by a penal authority; or
(D) Required to reside in a mental health facility under a penal statute or rule.
(ii) Individuals who are not considered to be in the custody of a penal authority include, but are not limited to, individuals who are—
(A) Released to the community pending trial (including those in pretrial community supervision and those released pursuant to cash bail);
(B) On parole;
(C) On probation;
(D) On home detention or home confinement; or
(E) Required to live in a halfway house or other community-based transitional facility."

Appeals:

A party to a claim denied in whole or in part under this policy may appeal the initial determination on the basis that, on the date of service, (1) the conditions of § 411.4(b)(1)(i) through (iii) were met, or (2) the beneficiary was not, in fact, in custody under authority of a penal statute.

A/B MAC (A)/RHHI Claims Processing Procedures

A/B MACs (A) must deny claims for items and services rendered to beneficiaries under custody when CWF rejects the claim. Provide appeal rights as specified above.

Providers that render items and services to individuals in custody of a penal authority in a jurisdiction that meets the conditions of 42 CFR 411.4(b)(1)(i) through (iii) should indicate the requirements have been met for payment on the claim by billing as follows:

For outpatient claims, providers shall append a HCPCS modifier QJ on all lines with a line item date of service during the incarceration period.

For inpatient claims where the incarceration period spans only a portion of the stay, hospitals shall identify the incarceration period by billing as non-covered all days,

services and charges that overlap the incarceration period. Non-coverage billing guidelines can be found in Pub. 100-04, Chapter 1, Section 60.

(**NOTE:** When the inpatient claim is correctly billed, the processing contractor will append the payer-only condition code 63, which will allow the claim to process for payment. This condition code indicates that the provider has been instructed by the state or local government agency that requested the healthcare items or services provided to the patient of the State or local government entity that it pursues collection of debts incurred for furnishing such items or services with the same vigor and in the same manner as any other debt.)

A/B MAC (B)/DME MAC Claims Processing Procedures

A/B MAC (B) and DME MACs must deny claims for items and services rendered to beneficiaries when rejected by CWF. Provide appeal rights as specified above.

Physicians and other suppliers that render items and services to individuals in custody of a penal authority in a jurisdiction that meets the conditions of 42 CFR 411.4(b)(1)(i) through (iii) should indicate the requirements have been met for payment on the claim. Providers should use the QJ modifier. Language approved for QJ reads:

"Services/items provided to a prisoner or patient in State or local custody, however, the State or local government, as applicable, meets the requirements in 42 CFR 411.4(b)(1)(i) through (iii)."

This modifier indicates that the physician or other supplier has been instructed by the state or local government agency that requested the healthcare items or services provided to the patient that State or local law makes the prisoner or patient responsible to repay the cost of Medical services and that it pursues collection of debts incurred for furnishing such items or services with the same vigor and in the same manner as any other debt.

10.5 - Claims Processing Requirements for Deported Beneficiaries
(Rev. 4201, Issued: 01-18-19, Effective: 02-19-19, Implementation: 02-19-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

Section 202(n) of the Social Security Act (the Act), requires the termination of Title II benefits upon deportation. Moreover, Sections 226 and 226(A) of the Act provide that no payments may be made for benefits under Part A of Title XVIII of the Act if there is no monthly benefit payable under Title II. Section 1836 of the Act limits Part B benefits to those who are either entitled to Part A benefits or who are age 65 and a United States (U.S.) resident, U.S. citizen, or

a lawfully admitted alien residing permanently in the U.S. Given that, a deported beneficiary is not allowed to enter the U.S. and cannot be lawfully present in the United States to receive Medicare-covered services, Medicare payment cannot be made for Part B Benefits.

An audit of Medicare payments by the Office of Inspector General identified a vulnerability for the Medicare trust fund with respect to this issue. The study identified improper payments for beneficiaries, who, on the date of service on the claim, had been deported. To address this vulnerability, CMS is establishing claim level editing using data from the Social Security Administration (SSA). Specifically, the data contains the name and Medicare beneficiary identifier of the Medicare beneficiary and the month the deportation is effective. CWF will reject claims where the effective date on the Master Beneficiary Record is equal to or greater than the date of service on the claim. All claims rejected by CWF shall be denied by the respective A/B MAC (B), DME MAC, A/B MAC (HHH) or A/B MAC (A) that submitted the claim to CWF.

Policy:

Medicare payment shall not be made for an item or service furnished to an individual that has been deported from the United States.

Appeals:
A party to a claim denied in whole or in part under this policy may appeal the initial determination on the basis of the deportation status at the time the item or service was furnished.

10.5.1 - Implementation of Payment Policy for Deported Medicare Beneficiaries

(Rev. 4201, Issued: 01-18-19, Effective: 02-19-19, Implementation: 02-19-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

A. CWF Editing of Claims

1. An auxiliary file shall be established in the Common Working File to contain deportation status.

2. This auxiliary file will be the basis for an edit that rejects claims submitted by Medicare contractors.

3. The edit will reject a claim where the Medicare beneficiary identifier on the claim matches the Medicare beneficiary identifier on the Master Beneficiary Record and the date of service is on or after the date of deportation.

B. Contractors Actions

Medicare contractors shall deny claims for items and services when rejected by CWF. The contractor shall refer to the CWF documentation on this subject for the error code assigned to this editing. All denials will provide appeal rights as specified in section 10.5.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: PR
CARC: 96
RARC: N126
MSN: 16.56

20 - Provider Assignment to FIs and MACs

(Rev. 1707; Issued: 03-27-09; Effective: 04-027-09; Implementation: 04-27-09)

A. The Process of Moving Providers from FIs to MACs

1. The General Case

An existing Medicare provider with a claims history will remain in its current workload assignment. As each MAC contract is awarded, the new MAC will take over workload from the carriers and FIs that serviced the state(s) in the given MAC jurisdiction. The Part A and Part B workload segments for each of the states in the given MAC jurisdiction will be moved one-by-one in the 12 months following the final award. The specific requirements associated with workload transfers will be directed through formal CMS transmittals.

A new provider (also known as an "initial enrollment") will be assigned to the FI or MAC that covers the state where the provider is located, unless the assignment is directed to a non-geographic workload by §20B below.

A special exception exists for a "Multi-Provider Complex/Sub-Unit" relationship (ref: 42 CFR 483.5(b)). An initial enrollment for a sub-unit will be assigned to the FI or MAC that currently serves the existing parent hospital – even if the parent hospital is not presently billing in accordance with the "geographic assignment rule." Each such case is fact-specific and will be treated on an individual basis.

2. Out of Jurisdiction Providers

An "out-of-jurisdiction provider" (OJP) is a provider that is not currently assigned to the A/B MAC or FI in accordance with §§B.1-5 below (including the geographic assignment rule.) For example, an individual, freestanding provider located in Maine, but currently assigned to the Wisconsin FI, would be an OJP.

Many legacy Part A workload segments may include a number of OJPs. Examples of how an OJP may have been assigned to the given Part A segment include:

a. Individual "provider nominations." (Note MMA §911 repealed the provider nomination provisions of the Act.);

b. Chains being granted "single FI" status; and

c. Legacy-world regional and national FIs for specific provider types such as FQHCs, RHCs, and ESRD facilities.

New MACs will initially service some OJPs until CMS undertakes the final reassignment of all OJPs to their destination MACs based on the geographic assignment rule and its exceptions.

CMS will start the overall transfer of OJPs to their final destination MACs after all 15 A/B MACs have been implemented. Each move will be dependent on the then-current implementation status of the systems that support the cost report audit, claims processing, and provider enrollment functions at the departure and destination MACs.

Some providers will need to submit or update their Medicare enrollment record before being reassigned.

B. The Settled MAC Environment

The "settled MAC environment" refers to the period after all OJPs have been moved to their destination MACs.

1. Home Health & Hospice

All home health and hospice (HH&H) providers will be assigned to the MAC contracted by CMS to administer HH&H claims for the geographic locale in which the provider is physically located.

2. Durable Medical Equipment

Each supplier of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) will submit claims to the DME MAC contracted by CMS to administer DMEPOS claims for the geographic locale in which the beneficiary permanently resides.

3. Qualified Railroad Retirement Beneficiaries Entitled to Medicare

Physicians and other suppliers (except for DMEPOS suppliers) will continue to enroll with and bill the contractor designated by the Railroad Retirement Board (under Section 1842(g) of The Act) for Part B services furnished to these beneficiaries. Suppliers of DMEPOS will bill the DME MACs.

4. Specialty Providers and Demonstrations

Specialty providers, and providers involved with certain demonstrations, will submit claims to a specific MAC designated by CMS. Examples of specialty providers and their corresponding MACs are:

Specialty Service	MAC Jurisdiction
Centralized Billing for Mass Immunizers	**4**
Indian Health Services/Federally Recognized Tribal Providers (Refer to Chapter 19 of this manual.)	**4**
Low Vision Demonstration	**5, 10, 11, 13, and 14**
Veterans Affairs Medicare Equivalent Remittance Advice Project	**4**
Home Health Third Party Liability Demonstration Project	**14**
Independent Organ Procurement Organizations	**10**
Religious Non-medical Health Care Institution (RNHCI)	**10**
Histocompatibility Lab	**10**

5. The Geographic-Assignment Rule

Medicare providers, physicians, and suppliers will generally be assigned to the A/B MAC that covers the state where the provider is located. This includes FQHCs, RHCs, and ESRD facilities.

An exception exists for qualified chain providers (QCPs). A QCP may request that its member providers be serviced by a single A/B MAC - specifically, the A/B MAC whose jurisdiction includes the QCP's home office. See 42 CFR 421.404 for QCP criteria and additional information.

A few providers that meet the "provider-based" criteria of 42 CFR 413.65 may present an additional exception to the geographic-assignment rule. Provider-based entities (other than HH+H providers) will be assigned to the MAC contracted by CMS to administer claims for the Medicare benefit category applicable to the provider's covered services for the geographic locale in which the main ("parent") provider is physically located.

20.1 - FI Service to HHAs and Hospices

(Rev. 1, 10-01-03)
A2-2807.B

Under 42 CFR 421.117, CMS is authorized to designate RHHIs to service HHAs and hospices. This provision was implemented through the designation of regional FIs to service all HHAs and hospices. See http://www.cms.hhs.gov/contacts/incardir.asp for RHHI jurisdictions.

An HHA or hospice chain may request to be served under an arrangement involving a lead FI serving its home office and regional FIs serving the individual facilities of the chain. Alternatively, a HHA or hospice chain may request to be served by a single designated regional intermediary. In either case, CMS does not grant requests automatically but rather requires the provider to demonstrate that the requested arrangement would be consistent with effective and efficient administration of the Medicare program.

For provider-based HHAs and hospices, audits, cost report settlements and other fiscal functions (such as setting interim payment rates) are performed by the FI serving the parent provider. The claims processing activities are performed by the designated RHHI for the provider.

20.2 - Provider Change of Ownership (CHOW)

(Rev. 861, Issued: 02-17-06; Effective: 10-01-05; Implementation: 03-17-06)

Providers (as defined in 1861(u) of the Act, and institutional suppliers such as RHCs) that undergo a change in their ownership structure are required to notify CMS concerning the identity of the old and new owners. They are also required to inform CMS on how they will organize the new entity and when the change will take place. A terminating cost report will be required from the seller owner in all CHOWs for certification purposes. There are five types of changes that can occur:

1. A CHOW in accordance with 42 CFR 489.18;

2. Changes in the ownership structure to an existing provider that do not constitute a CHOW;

3. A new owner who purchases a participating provider but elects not to accept the automatic assignment of the existing provider agreement, thus avoiding the old owner's Medicare liabilities;

4. An existing provider who acquires another existing provider (acquisition/merger); and

5. Two or more existing providers who are totally reorganizing and becoming a new provider (consolidation).

Providers that undergo a change of ownership will usually continue with the same FI that served the previous owner. However, if the prospective owner does not wish to accept the automatic assignment of the existing provider agreement, this means that the existing provider agreement is terminated effective with the CHOW date. The regional office must be notified in writing of the CHOW per instructions contained in section 3210.5 of the State Operations Manual. The prospective owner provides a notice 45 -days in advance of the CHOW to the CMS/RO to allow for the orderly transfer of any beneficiaries that are patients of the provider. All reasonable steps must be taken to ensure that beneficiaries under the care of the provider are aware of the prospective termination of the agreement. There may be a period when the facility is not participating and beneficiaries must have sufficient time and opportunity to make other arrangement for care prior to the CHOW date.

After the CHOW has taken place, the RO acknowledges the refusal to accept assignment in a letter to the new owner, with copies to the State Agency (SA) and the FI. The RO completes a form CMS-2007 with the date the agreement is no longer in effect, noting that the termination is due to the new owner's refusal to accept assignment of the provider agreement.

If the new owner refuses to accept assignment and also wishes to participate in the Medicare program, the RO will first process the refusal as indicated above and then treat the new owner as it would any new applicant to the program. The RO will obtain and process the application documents, have the SA perform an initial survey and if all the requirements for participation are met, assign an effective date of participation. The earliest possible effective date for the applicant is the date that the RO determines that all Federal requirements are met. Once this is completed, a new provider agreement with a new provider number will be issued to the new owner. The provider will be assigned to the local FI.

See chapter 10, of the Medicare Program Integrity Manual, for complete requirements for completion of Form CMS-855 in change of ownership situations.

20.3 - CMS No Longer Accepts Provider Requests to Change Their FI

(Rev. 2876, Issued: 02-07-14, Effective: 03-07-14, Implementation: 03-07-14)

Medicare providers will no longer be able to request a change of FI, they must remain with the FI to which they have been assigned.

30 - Provider Participation

(Rev. 1, 10-01-03)
A2-2810

The RO uses the provider tie-in notice, Form CMS-2007 (see the CMS forms page at http://www.cms.hhs.gov/forms/), as an official notification to the FI of a change in its list of providers. The RO completes and transmits a Form CMS-2007 to the home office of the FI in each of the following circumstances:

- A provider is certified for participation in the program,
- A provider is issued a notice of termination,
- A change of FI is authorized (including changes between Blue Cross plans or between FI processing facilities, i.e., any changes involving a change in the FI number), or
- To correct information previously furnished the FI.

Part I of the Form CMS-2007, Identifying Information, identifies the provider and is always completed.

Part II, New Provider Certification, is completed where the provider is certified (including certifications required because of a change of ownership).

Part III, Change of FI, is completed where a change of FI has been authorized.

Part IV, Terminations, is completed in all termination actions.

Part V, Remarks, will be used for additional clarifying information.

The FI must promptly notify the RO of any information found to be incorrect. The RO will issue a corrected Form CMS-2007.

30.1 - Content and Terms of Provider Participation Agreements

(Rev. 1, 10-01-03)
A2-2840, RHC-320

In the agreement/attestation statement signed by a provider serviced by an FI, the provider agrees to maintain its compliance with all of the conditions for certification in 42 CFR 491. If a provider fails to maintain compliance with one or more of the conditions, it must promptly report this (usually within 30 days of the failure) to the responsible CMS office or official. Failure to report promptly may be a cause for termination of the provider's agreement.

30.1.1 - Provider Charges to Beneficiaries

(Rev. 2921, Issued: 04-04-14, Effective: 05-05-14, Implementation: 05-05-14)

In the agreement/attestation statement signed by a provider, it agrees not to charge Medicare beneficiaries (or any other person acting on a beneficiary's behalf) for any service for which Medicare beneficiaries are entitled to have payment made on their behalf by the Medicare program. This includes items or services for which the beneficiary would have been entitled to have payment made had the provider filed a request for payment (see §50).

The provider may bill the beneficiary for the following items:

- Part A deductible;
- Part B deductible;
- First 3 pints of blood, which is called the blood deductible (if there is a charge for blood or the blood is not replaced);
- Part B coinsurance;
- Part A coinsurance; or
- Services that are not Medicare covered services. See Chapter 30 for related requirements.

SNFs may not require, request, or accept a deposit or other payment from a Medicare beneficiary as a condition for admission, continued care, or other provision of services, except as follows:

- A SNF may request and accept payment for a Part A deductible and coinsurance amount on or after the day to which it applies.
- A SNF may request and accept payment for a Part B deductible and coinsurance amount at the time of or after the provision of the service to which it applies.
- A SNF may not request or accept advance payment of Medicare deductible and coinsurance amounts.
- A SNF may require, request, or accept a deposit or other payment for services if it is clear that the services are not covered by Medicare and proper notice is provided. See Chapter 30 for instructions about ABNs and demand bills.
- SNFs, but not hospitals, may bill the beneficiary for holding a bed during a leave of absence if the requirements in §30.1.1.1 are met.

30.1.1.1 - Charges to Hold a Bed During SNF Absence

(Rev. 4001, Issued: 03-16-18, Effective: 06- 19- 18, Implementation: 06-19-18)

Charges to the beneficiary for admission or readmission are not allowable. However, when temporarily leaving a SNF, a resident can choose to make bed-hold payments to the SNF.

Bed-hold payments are readily distinguishable from payments made prior to initial admission, in that the absent individual has already been admitted to the facility and has

established residence in a particular living space within it. Similarly, bed-hold payments are distinguishable from payments for readmission, in that the latter compensate the facility merely for agreeing in advance to allow a departing resident to reenter the facility upon return, while bed-hold payments represent remuneration for the privilege of actually maintaining the resident's personal effects in the particular living space that the resident has temporarily vacated.

One indicator that post-admission payments do, in fact, represent permissible bed-hold charges related to maintaining personal effects in a particular living space (rather than a prohibited charge for the act of readmission itself) would be that the charges are calculated on the basis of a per diem bed-hold payment rate multiplied by however many days the resident is absent, as opposed to assessing the resident a fixed sum at the time of departure from the facility.

Under §1819(c)(1)(B)(iii) of the Act and 42 CFR 483.10(g)(17)-(18), the facility must inform residents in advance of their option to make bed-hold payments, as well as the amount of the facility's charge. For these optional payments, the facility should make clear that the resident must affirmatively elect to make them prior to being billed. A facility cannot simply deem a resident to have opted to make such payments and then automatically bill for them upon the resident's departure from the facility.

30.1.2 - Provider Refunds to Beneficiaries

(Rev. 1, 10-01-03)
RHC-322

In the agreement between CMS and a provider, the provider agrees to refund as promptly as possible any money incorrectly collected from Medicare beneficiaries or from someone on their behalf.

Money incorrectly collected means any amount for covered services that is greater than the amount for which the beneficiary is liable because of the deductible and coinsurance requirements.

Amounts are considered to have been incorrectly collected because the provider believed the beneficiary was not entitled to Medicare benefits but:

- The beneficiary was later determined to have been entitled to Medicare benefits;
- The beneficiary's entitlement period fell within the time the provider's agreement with CMS was in effect; and
- Such amounts exceed the beneficiary's deductible, coinsurance or non covered services liability.

30.1.3 - Provider Treatment of Beneficiaries
(Rev.4163, Issued: 11-02-18, Effective: 12-04-18, Implementation: 12-04-18)

In the agreement between CMS and a provider, the provider agrees to accept Medicare beneficiaries for care and treatment. The provider cannot impose any limitations with respect to care and treatment of Medicare beneficiaries that it does not also impose on all other persons seeking care and treatment. If the provider does not furnish treatment for certain illnesses and conditions to patients who are not Medicare beneficiaries, it need not furnish such treatment to Medicare beneficiaries in order to participate in the Medicare program. It may not, however, refuse to furnish treatment for certain illnesses or conditions to Medicare beneficiaries if it furnishes such treatment to others. Failure to abide by this rule is a cause for termination of the provider's agreement to participate in the Medicare program (see the regulations at 42 CFR 489.53(a)(2), and also see Pub. 100-01, Medicare General Information, Eligibility, and Entitlement Manual, chapter 5, §10.2).

30.2 - Assignment of Provider's Right to Payment
(Rev. 1, 10-01-03)
A3-3488, A3-3703.1, B3-3060

Except as provided in §30.2.1, FIs pay benefits due a provider only to the provider.

Carriers may pay assigned benefits only to the physician, practitioner, or supplier who furnished the service. They do not pay the benefits to any other person or organization under an assignment or reassignment, power of attorney, or under any other arrangement in which the other person or organization receives the payment directly. For this purpose, assigned benefits include, in addition to the benefits usually encompassed by this term, benefits payable after the death of the enrollee to the physician or other supplier on the basis of his agreement to accept the reasonable charge as the full charge. A power of attorney for this purpose means a written authorization by a principal to an agent:

- To receive in the agent's own name amounts due the principal;
- To negotiate checks payable to the principal; or
- To receive in any other manner direct payment of amounts due the principal.

The prohibition against assignment of a provider's benefits also applies to payment of benefits due a provider as a reassignee of the physician.

Payment is considered to be made directly to an ineligible person or organization if that person or organization can convert the payment to its own use and control without the payment first passing through the control of the provider or other party eligible to receive the payment under the exceptions in §30.2.1. (For payment to a bank, see §30.2.5.)

Forwarding of amounts due a provider to its home office is not affected by the prohibition described in this section. Reimbursement amounts for providers of a chain organization may be forwarded to a central location of the home office when it has set up

a lock box or special bank account and the FI has secured a **written** assignment or other authorization from the respective provider(s) that payment may be sent to the home office. The payments must be made out in the individual provider's name and payment may be made by check or electronic funds transfer (EFT).

Establishment of internal controls and other related administrative details necessary to effect these payments are left to the individual contractors involved. However, FIs must be sure that the individual signing the assignment can legally bind the provider. Payment under those procedures is payment to the provider.

30.2.1 - Exceptions to Assignment of Provider's Right to Payment – Claims Submitted to A/B MACs

(Rev. 3774, 05-12-17, Effective: 06-13-17, Implementation: 06-13-17)

A. Payment to Government Agency

Medicare payment for the services of a provider is not made to a governmental agency or entity except when payment to the governmental agency or entity is permissible under the other listed reassignment exceptions, e.g., where the agency is the employer of the physician.

B. Payment Pursuant to Court Order

The Medicare program may make payment in accordance with an assignment established by, or pursuant to the order of, a court of competent jurisdiction. The assignment must satisfy the conditions set forth in §30.2.

C. Payment to Agent

The Medicare program may make payment, in the name of the provider, to an agent who furnishes billing or collection services. The payment arrangement must satisfy the conditions in §30.2.4.

D. Payment to Employer

The A/B MAC Part B may pay the employer of the physician or other supplier if the physician or other supplier is required, as a condition of his employment, to turn over to his employer the fees for his services. (See §30.2.6.)

E. Payment for Services Provided Under a Contractual Arrangement

The A/B MAC Part B may make payment to an entity enrolled in the Medicare program for services provided by a physician or other person under a contractual arrangement with that entity. The services may be furnished on or off the premises of the entity submitting the claim. Both, the entity submitting the claim and receiving payment and the physician

or other person under contract are subject to certain program integrity requirements. (See §30.2.7.)

F. Payment for Anti-Markup Tests

The A/B MAC Part B may pay a physician (or a physician's medical group) or other supplier for the TC or PC of diagnostic tests (other than clinical diagnostic laboratory tests) that the physician or other supplier contracts an independent physician, medical group, or other supplier to perform. The anti-markup payment limitation applies when the performing physician or other supplier does not meet the criteria for sharing a practice with the billing physician or other supplier. The contracting physician, physician's group, or other supplier must accept as payment in full the lower of: (a) the acquisition price; (b) the submitted charge for the service; or (c) the fee schedule amount. (See §30.2.9, of this chapter, for additional information on the anti-markup payment limitation.)

G. Payment Under Reciprocal Billing Arrangements

The A/B MAC Part B may pay the patient's regular physician for physicians' services and services furnished incident to such services that are provided to the regular physician's patients by another physician on an occasional reciprocal basis and certain other requirements are met. Also, in the case of outpatient physical therapy services furnished by physical therapists in a health professional shortage area (HPSA), a medically underserved area (MUA), or a rural area, the A/B MAC Part B may pay the patient's regular physical therapist for such services that are provided to his/her patients by another physical therapist on an occasional reciprocal basis and certain other requirements are met. (See §30.2.10.)

H. Payment Under Fee-For-Time Compensation Arrangements (formerly referred to as Locum Tenens Arrangements)

The A/B MAC Part B may pay the patient's regular physician for physicians' services and services furnished incident to such services that are provided by a substitute physician during the absence of the regular physician where the regular physician pays the substitute on a per diem or similar fee-for-time basis, and certain other requirements are met. Also, in the case of outpatient physical therapy services furnished by physical therapists in a HPSA, a MUA, or a rural area, the A/B MAC Part B may pay the patient's regular physical therapist for such services that are provided by a substitute physical therapist where the regular physical therapist pays the substitute on a per diem or similar fee-for-time basis, and certain other requirements are met. (See §30.2.11.)

30.2.2 - Background and Purpose of Reassignment Rules - Claims Submitted to B/MACs

(Rev. 1931, Issued: 03-12-10, Effective: 06-14-10, Implementation: 06-14-10)

In 1972, Congress acted to stop a practice under which some physicians and other suppliers providing covered services reassigned their Medicare and Medicaid receivables to other organizations and groups, which then claimed and received payment. Often the organizations acquired the claims at a percentage of face value. It had become apparent that such reassignments were a source of incorrect, inflated, and even fraudulent Medicare and Medicaid claims. The Social Security Act Amendments of 1972, Public Law 92-603, enacted a prohibition against payment on a charge basis for covered services to anyone other than the patient, physician or other person who provided the service, with limited exceptions.

Thereafter, some physicians and other suppliers circumvented the intent of the law by granting a power of attorney. This allowed the factoring company or other person to receive the Medicare or Medicaid payments in the name of the physician or other supplier, thus permitting continuation of program abuses.

Section 2(a) of Public Law 95-142, dated October 25, 1977, modified existing law to preclude the use of power of attorney as a device for reassignment of benefits under Medicare, subject to limited exceptions. It also provides for a similar prohibition with respect to payment for care furnished by providers.

These provisions preclude Medicare payment of amounts due a provider or other person to a person or entity furnishing financing to the provider, whether the provider sells the provider's claims to that person or entity or pledges them to that person or entity as collateral on a loan.

A. Who is Supplier of Services

The question of reassignment arises only when assigned payment is made to someone other than the physician or other practitioner or supplier that furnished the services.

A supplier may be an individual, partnership, corporation, trust, or estate. Any services furnished by an employee of the supplier are considered furnished by the supplier if those services are within the scope of the employment. Where the supplier is a partnership, any services furnished by a partner are considered furnished by the supplier if those services are within the scope of the partnership agreement. Therefore, issues of reassignment are limited to claims submitted to B/MACs.

Services that one physician or other supplier purchases from another are not usually considered furnished by the purchasing supplier for purposes of the prohibition on reassignment.

When one supplier purchases or rents items (as distinguished from services) from another supplier and resells or re-rents those items to the beneficiary, no reassignment issue arises. The supplier that sells or rents the items to the beneficiary is considered to furnish them.

In the case of drugs used in conjunction with durable medical equipment (DME) or prosthetic devices, the entity that dispenses the drug must furnish it directly to the patient for whom a prescription is written. Therefore, those drugs cannot be purchased for resale to the beneficiary by any supplier that is not the entity that dispenses the drugs. Such a supplier may only bill for the DME or prosthetic devices. In order for prescription drugs that are used in conjunction with DME or prosthetic devices to be covered by Medicare, the entity that dispenses the drugs must have a Medicare supplier number, must be licensed to dispense the drug in the State in which the drug is dispensed, and must bill and receive payment in its own name.

B. Effect of Payment to Ineligible Recipient

An otherwise correct Medicare payment made to an ineligible recipient under a reassignment or other authorization by the physician or other supplier does not constitute a program overpayment. Sanctions may be invoked under §30.2.15 against a physician or other supplier to prevent him from executing or continuing in effect such an authorization in the future, but neither the physician nor other supplier nor the ineligible recipient is required to repay the Medicare payment. See chapter 10 of the Medicare Program Integrity Manual for appeal rights of physicians and physician groups when billing numbers are revoked for non-compliance with the reassignment rules. Appeal rights for prospective and existing providers can be found at 42 CFR §498 of the Medicare regulations.

C. Effect of Reassignment on Assignment Agreement

An assignment is an agreement between a physician (or other supplier of services) and an enrollee where the enrollee transfers to the physician his/her right to benefits based on covered services specified on the assigned claim. The physician in return agrees to accept the approved charge determination by the B/MAC as his/her full charge for the items or services. In effect, the physician who accepts assignment is precluded from charging the enrollee more than the deductible and coinsurance based upon the approved charge determination.

When a qualified entity accepts assignment for a service furnished by a physician (thereby agreeing to collect no more than the Medicare deductible and coinsurance based on the allowed amount from the beneficiary), it is the entity and not the physician that is bound by the terms of the assignment. In this situation, the physician may accept from the entity a set fee or other payment that is greater than the reasonable charge, without violating the terms of the assignment. If the entity pays the physician such amount, the entity must absorb any loss resulting from the excess of the payment to the physician over the reasonable charge. An entity may accept assignment for a physician's services only if the employment or other contractual arrangement between the entity and the physician provides that it alone has the right to bill and receive the payment for the services. The beneficiary is fully protected against any liability for the difference between the reasonable charge and any higher fee owed by the entity to the physician,

since only the entity may collect from the beneficiary, and then only in the amount of the applicable deductible and coinsurance.

When a physician or non-physician practitioner opts out of the Medicare program and is a member of a group practice or otherwise reassigns his or her right to bill and receive Medicare payment to an organization, the organization may no longer bill Medicare or receive Medicare payment for the services that the opt out physician or non-physician practitioner furnishes to Medicare beneficiaries. However, if the opt out physician or non-physician practitioner continues to grant the organization with the right to bill and receive payment for the services he or she furnishes to patients, the organization may bill and be paid by the beneficiary for the services that are provided under the private contract. In addition, the decision of a physician or non-physician practitioner to opt out of Medicare does not affect the ability of the group practice or organization to bill Medicare for the services of physicians and/or non-physician practitioners who have not opted out of Medicare.

Suppliers not enrolled in Medicare may not receive payment.

30.2.2.1 - Reassignments by Nonphysician Suppliers - Claims Submitted to FIs

(Rev. 1, 10-01-03)

Definition of Participating From MIM 3005

Nonphysician suppliers may reassign benefits under conditions similar to those under which physicians reassign benefits. Note, however, that when a supplier furnishes services to patients of a participating provider (e.g., a participating hospital or SNF) under arrangement (within the meaning of §1861(w) of the Act), the provider, not the supplier, is reimbursed by Medicare. No reassignment is involved since the provider is then responsible for paying subcontracting providers/suppliers under these payment structures.

To be a **participating** provider under Medicare, a provider must be in compliance with the applicable provisions of title VI of the Civil Rights Act of 1964 and must enter into an agreement under §1866 of the Act which provides that it (1) will not charge any individual or other person for items and services covered by the health insurance program other than allowable charges and deductibles and coinsurance amounts; and (2) will return any money incorrectly collected from the individual or other person on his behalf or make such other disposition as described in §30.1 (See also §30.1 on participation agreements).

30.2.3 - Effect of Payment to Ineligible Recipient

(Rev. 1, 10-01-03)

An otherwise correct Medicare payment made to an ineligible recipient under an assignment or other authorization by the provider does not constitute a program

overpayment. Sanctions may be invoked against a provider (see §30.2.15) to prevent it from executing or continuing in effect such an authorization in the future. Neither the provider nor the ineligible recipient is required to repay the Medicare payment.

30.2.4 - Payment to Agent - Claims Submitted to Carriers

(Rev. 1, 10-01-03)
A3-3488.1, B3-3060.10

A. Conditions

The FI or carrier makes payment **in the name of the provider** (Carriers additionally may pay in the name of supplier or employer, facility, or organized health care delivery system.) to an agent who furnishes billing or collection services if:

- The agent receives the payment under an agreement between the provider and the agent;
- The agent's compensation is not related in any way to the dollar amount billed or collected;
- The agent's compensation is not dependent upon the actual collection of payment;
- The agent acts under payment disposition instructions which the provider may modify or revoke at any time; and
- In receiving the payment, the agent acts only on behalf of the provider (except insofar as the agent uses part of that payment to compensate the agent for the agent's billing and collection services).

For this purpose, an agency is an entity that provides computer and other billing services to prepare claims, and receive and process Medicare benefit checks for the provider, supplier, physician or other practitioner.

B. Background

The primary purpose of this exception is to permit computer and other billing services to claim and receive Medicare payment on behalf of and in the name of the provider, supplier or eligible party). The conditions for payment insure that the billing agent has no financial interest in how much is billed or collected and is not acting on behalf of someone who has such an interest, other than the provider/supplier itself.

The conditions specified in subsection A do not apply if the agent merely prepares bills for the provider and does not receive and negotiate the checks payable to the provider/supplier.

The conditions specified in subsection A also do not apply where the entity receiving payment in the name of the physician qualifies to receive payment for the physician's services by definition in law and regulations. Thus, a hospital which is entitled to bill and receive payment in its name for a physician's service under §30.2.7 may bill and receive payment in the physician's name (negotiating the checks under a power of attorney) even though its compensation is related to the amount billed or collected or is dependent on collection.

C. Documentation

If payment is being made or requested to be made in the name of a provider to an agent, the contractor assumes that the conditions for such payment are met in the absence of evidence to the contrary. If there is evidence to the contrary, the agent must document the agreement by submitting to the contractor a copy of the written agreement. The written agreement may be a formal legal document or merely an exchange of correspondence. If there is no written agreement of either a formal or informal nature or all the required conditions for payment are not clear in the agreement, the contractor obtains a statement from the agent describing the pertinent terms of the agreement or of those provisions that need to be clarified. The contractor verifies the agent's allegations by obtaining statements from one or more providers/physicians/suppliers that have agreements with the agent. See §30.2.14.1.D for reviewing endorsements on benefit checks.

30.2.5 - Payment to Bank

(Rev. 213, 06-25-04)
A3-3488.2, B3-3060.11

Medicare payments due a provider or supplier of services may be sent to a bank (or similar financial institution) for deposit in the provider/supplier's account so long as the following requirements are met:

- The bank may provide financing to the provider/supplier, as long as the bank states in writing, in the loan agreement, that it waives its right of offset. Therefore, the bank may have a lending relationship with the provider/supplier and may also be the depository for Medicare receivables; and

- The account is in the provider/supplier's name only and only the provider/supplier may issue any instructions on that account. The bank shall be bound by only the provider/supplier's instructions. No other agreement that the provider/supplier has with a third party shall have any influence on the account. In other words, if a bank is under a standing order from the provider/supplier to transfer funds from the provider/supplier's account to the account of a financing entity in the same or another bank and the provider/supplier rescinds that order, the bank honors this rescission notwithstanding the fact that it is a breach of the provider/supplier's agreement with the financing entity.

Irrespective of the language in any agreement a provider/supplier has with a third party that is providing financing, that third party cannot purchase the provider/supplier's Medicare receivables.

Subject to the above restrictions on the bank and to the bank's meeting the conditions specified in §30.2.4, a bank which is the provider/supplier's billing agent pursuant to an agreement with the provider/supplier and receives and deposits in the provider/supplier's bank account the provider/supplier's Medicare payments may, subject to instructions from the provider/supplier, draw on those funds to pay for its billing services.

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

Notwithstanding the above restrictions, if a court of competent jurisdiction orders the assignment or reassignment of Medicare payments, Medicare will follow that order if, as stated in 42 C.F.R. §424.73(b)(2) and listed in 42 C.F.R. §424.90, a certified copy of the court order and of the executed assignment or reassignment (if it was necessary to execute one) is filed with the contractor responsible for processing the claim and the assignment or reassignment (1) applies to all Medicare benefits payable to a particular person or entity during a specified or indefinite time period; or, (2) specifies a particular amount of money, payable to a particular person or entity by the particular contractor. In all other instances, the Medicare program will make payments subject to the restrictions listed above. For example, even if a court order directed to a provider/supplier limits the provider/supplier's ability to breach its financial agreement with a third party, the bank is bound by instructions from the provider/supplier.

30.2.6 - Payment to Employer of Physician - Carrier Claims Only

(Rev. 1, 10-01-03)
B3-3060.1

The carrier may pay Part B benefits for covered physician services under an assignment or for enrollees that did not execute assignment before death to the physician's employer, provided that under the terms of the physician's employment, only the employer and not the physician has the right to charge or collect charges for the physician's services, and certain other conditions and limitations described below are met. There must be an employer-employee relationship between the physician and the person or organization hiring the physician to perform services, and the terms of the employment must provide that the employer and not the physician has the right to receive the payment for all the latter's services within the scope of the employment. If the employer has the right, as a condition of employment, to fees for all professional services the physician renders,

including those outside the scope of the employment, honor an assignment of benefits to the employer for all such services.

An employer may establish that it qualifies to receive payment for the services of its physicians by submitting the Form CMS-855R.

The employer must provide evidence that the employee is a valid employee by providing the carrier with a Form W-2 or other acceptable Internal Revenue Service documentation (a pay stub would suffice for new employees who do not yet have a Form W-2.).

30.2.7 - Payment for Services Provided Under a Contractual Arrangement - Carrier Claims Only

(Rev. 472, Issued: 02-11-05, Effective: 01-01-05, Implementation: 03-15-05)

A carrier may make payment to an entity (i.e., a person, group, or facility) enrolled in the Medicare program that submits a claim for services provided by a physician or other person under a contractual arrangement with that entity, regardless of where the service is furnished. Thus, the service may be furnished on or off the premises of the entity submitting the bill and receiving payment. The entity receiving payment and the physician or other person that furnished the service are both subject to the following program integrity safeguard requirements:

1. The entity receiving payment and the person that furnished the service are jointly and severally responsible for any Medicare overpayment to that entity; and,

2. The person furnishing the service has unrestricted access to claims submitted by an entity for services provided by that person.

30.2.8.2 - University-Affiliated Medical Faculty Practice Plans - Claims Submitted to Carriers

(Rev. 1, 10-01-03)
B3-3060.3.D

A carrier may make Part B payment to a university-affiliated medical faculty practice plan that has the following attributes:

- There is a written agreement between the Governing Board of the University and the Governing Board of the Medical Faculty Practice Plan describing the relationship between both parties.

- The Medical Faculty Practice Plan is a 501(c)(3) nonprofit tax-exempt organization, according to IRS regulations.

- Physicians of the faculty practice plan are employees of the University and/or medical school. The plan should furnish a copy of the employment agreement(s) between the faculty physician and the University.

- Physicians are full or part-time faculty members of the University's School of Medicine, licensed to practice medicine in the State.

- The faculty practice plan may only be affiliated with one University, and this relationship is described in the written agreement between the University and the Medical Faculty Practice Plan.

- Members of the faculty practice plan are represented on the Governing Board of the practice plan. The Board has the authority to make or delegate management and operational decisions on behalf of the physicians participating in the practice plan.

- Faculty practice plan physicians have unrestricted access to the billing records, medical documentation, and claims forms for services submitted on their behalf by the practice plan. The faculty practice plan provides documentation establishing the existence of this policy.

- The physicians abide by the rules and regulations of the Medical Faculty Practice Plan.

- The faculty practice plan is accountable to Medicare for any claims that are submitted on behalf of the plan's physicians for services provided to Medicare beneficiaries. Thus, the plan is responsible for refunding any overpayments to Medicare that are collected on behalf of the plan's physicians.

Both the Medical Faculty Practice Plan and the plan's physicians must enroll in the Medicare program by completing the Form CMS-855B and Form CMS-855R (Medicare health care provider/supplier enrollment application forms). Instructions for processing Form CMS-855B are referenced in Program Integrity Manual.

For those entities that are part of the organizational structure of the University, see §30.2.12, on payment to special accounts. These entities may include departments, specialties, practice plans, or similar subdivisions of a university or medical school.

30.2.8.3 - Indirect Payment Procedure (IPP) - Payment to Entities that Provide Coverage Complementary to Medicare Part B
(Rev. 2896, Issued: 03-07-14, Effective: 06-06-14, Implementation: 06-06-14)

Medicare Part B payment otherwise payable to a beneficiary for the services of a physician or supplier who charges on a fee-for-service basis may be paid to an entity using the indirect payment procedure (IPP). Any entity registered in accordance with the instructions in Pub. 100-08, chapter 15, sections 15.7.9 through 15.7.9.7 and meets the following requirements can bill using the IPP:

- Provides coverage of the service under a complementary health benefit plan (this is, the coverage that the plan provides is complementary to Medicare and covers only the amount by which the Part B payment falls short of the approved charge for the service under the plan).

- Has paid the person who provided the service an amount (including the amount payable under the Medicare program) that the person accepts as full payment.

- Has the written authorization of the beneficiary (or of a person authorized to sign claims on the beneficiary's behalf under 42 C.F.R. §424.36) to receive the Part B payment for the services for which the entity pays.

- Relieves the beneficiary of liability for payment for the service and will not seek any reimbursement from the beneficiary, his or her survivors, or estate.

- Submits any information CMS or the contractor may request, including an itemized physician or supplier bill, in order to apply the requirements under the Medicare program.

- Identifies and excludes from its requests for payment all services for which Medicare is the secondary payer.

Entities that satisfy all of the requirements above may include employers, unions, insurance companies, and retirement homes. They also may include health care prepayment plans, health maintenance organizations (HMOs), competitive medical plans, and Medicare Advantage organizations. The IPP permits a physician or supplier to file a single claim with the complementary insurer and receive full payment in a single payment, relieves the beneficiary of the need to file a claim, and protects the beneficiary against any financial liability for the service.

Because section 1842(h)(1) of the Social Security Act only permits "physicians and suppliers" to enter into participation agreements and because IPP entities do not meet the definition of a "supplier" as described in 42 C.F.R. §400.202, IPP entities cannot enter into a participation agreement (Form CMS-460) with Medicare. Therefore, IPP claims are paid at the non-participating physician/supplier rate, which is 95% of the physician fee schedule amount.

Payment under the IPP can only be made for covered Part B services. If an IPP entity submits a claim for a beneficiary's service that has already been billed to Medicare (for example, the claim was submitted by a physician before the IPP entity submitted its claim), then Medicare cannot make payment to the IPP entity for that same service. Conversely, if a physician or supplier submits a claim for a beneficiary's service that has already been billed to Medicare (for example, the claim was submitted by an IPP entity before the physician submitted his/her claim), then Medicare cannot make payment to the physician for that same service. Medicare payment can only be made once for a

beneficiary's specific service. Therefore, claims for services that have already been billed to Medicare shall be denied (with appeal rights) by Medicare's contractors.

In addition, Medicare payment cannot be made under the IPP for services that are payable for a particular beneficiary under any other Part of Medicare. For example, if a beneficiary's service is payable under Part C and a Medicare Advantage organization is also an IPP entity under 42 C.F.R. §424.66, then a Medicare Part B payment under the IPP cannot be made to that Medicare Advantage organization for that beneficiary's service. In these types of dual or multiple enrollment situations, services that are payable under those other Parts of Medicare (e.g., Parts C or D) cannot also be billed and paid for under Part B. Therefore, IPP entities that submit Part B claims for services that are payable under another Part of Medicare (e.g., Part C or D) shall be denied (with appeal rights) by Medicare's contractors.

Payment for IPP claims by Medicare is conditioned upon the claim and the underlying transaction complying with the Medicare laws, regulations, and program instructions applicable to IPP entities, and on the IPP entity's continued compliance with the regulatory requirements described in 42 C.F.R. §424.66.

30.2.9 Payment to Physician or Other Supplier for Diagnostic Tests Subject to the Anti-Markup Payment Limitation - Claims Submitted to A/B MACs (Part B)

(Rev. 4473, Issued: 12-6-19; Effective: 3-9-20; Implementation: 3-9-20)

A physician or other supplier may bill for the technical component and/or professional component of a diagnostic test that was ordered by the physician or other supplier (or ordered by a party related to the billing physician or other supplier through common ownership or control), subject to an anti-markup payment limitation, if the diagnostic test is performed by a physician who does not "share a practice" with the billing physician or other supplier. (This claim and payment limitation does not apply to clinical diagnostic laboratory tests, which are paid under the Clinical Laboratory Fee Schedule.) Under the anti-markup payment limitation, payment to the billing physician or other supplier (less the deductibles and coinsurance paid by the beneficiary or on behalf of the beneficiary) for the technical component or professional component of the diagnostic test may not exceed the lowest of the following amounts:

(1) The performing physician/supplier's net charge to the billing physician or other supplier.* (With respect to the technical component, the performing supplier is the physician who supervised the test, and with respect to the professional component, the performing supplier is the physician who performed the professional component;

(2) The billing physician or other supplier's actual charge; and

(3) The fee schedule amount for the test that would be allowed if the performing physician or other supplier billed directly. (See section 10.1.1.2 for information on payment jurisdiction for services subject to the anti-markup payment limitation.)

* The net charge must be determined without regard to any charge that is intended to reflect the cost of equipment or space leased to the performing supplier by or through the billing physician or other supplier.

Exception to the Anti-markup Payment Limitation

If the performing physician is deemed to "share a practice" with the billing physician or other supplier (who ordered the test), the anti-markup payment limitation does not apply. A performing physician is considered to "share a practice" with the billing physician or other supplier if the performing physician furnishes "substantially all" (at least 75 percent) of his or her professional services through the billing physician or other supplier. The "substantially all" services requirement will be satisfied, if, at the time the billing physician or other supplier submits a claim for a service furnished by the performing physician, the billing physician or other supplier has a reasonable belief that: (1) for the 12 months prior to and including the month in which the service was performed, the performing physician furnished substantially all of his or her professional services through the billing physician or other supplier; or (2) the performing physician will furnish substantially all of his or her professional services through the billing physician or other supplier for the next 12 months (including the month in which the service is performed).

If the performing physician does not meet the "substantially all" services test, the performing physician may be deemed to "share a practice" with the billing physician or other supplier if the arrangement complies with a "site of service/same building" test. This alternative approach requires the performing physician to be an owner, employer, or independent contractor of the billing physician or other supplier and requires that the technical component or professional component be performed "in the office of the billing physician or other supplier." The "office of the billing physician or other supplier" is any medical office space, regardless of the number of locations, in which the ordering physician or other supplier regularly furnishes patient care, and includes space where the billing physician or other supplier furnishes diagnostic testing services, if the space is located in the "same building" (as defined in 42 CFR §411.351 of the physician self-referral rules) in which the ordering physician or other ordering supplier regularly furnishes patient care. With respect to a billing physician or other supplier that is a physician organization (as defined in 42 CFR §411.351 of the physician self-referral rules), the "office of the billing physician or other supplier" is space in which the ordering physician provides substantially the full range of patient care services the ordering physician provides generally. The performance of the technical component includes, both, the conducting of the technical component as well as the supervision of the technical component.

The billing physician or other supplier must keep on file the name, the National Provider Identifier, and address of the performing physician. The physician or other supplier furnishing the technical component or professional component of the diagnostic test must be enrolled in the Medicare program. No formal reassignment is necessary.

NOTE: When billing for the technical component or professional component of a diagnostic test (other than a clinical diagnostic laboratory test) that is performed by another physician, the billing entity must indicate the name, address and NPI of the performing physician or other supplier in Item32 of the Form CMS-1500 claim form.

Effective for claims submitted with a receipt date on and after October 1, 2015, for reference laboratory and anti-markup claims, the billing physician or supplier must report the name, address, and NPI of the performing physician or supplier in Item 32a of the CMS-1500 claim form (or its electronic equivalent), even if the performing physician or supplier is enrolled in a different A/B MAC (Part B) jurisdiction. See §10.1.1.2 for more information regarding claims filing jurisdiction.

If the billing physician or other supplier performs only the technical component or the professional component and wants to bill for both components of the diagnostic test, the TC modifier and 26 modifier must be reported as separate line items if billing electronically (ASC X12 837 professional claim) or on separate claims if billing on paper (Form CMS-1500). Global billing is not allowed unless the billing physician or other supplier performs both components.

Effective for claims received on or after April 1, 2004:

In order to have appropriate service facility location ZIP code and the acquired price of each test on the claim, when billing for anti-markup tests on the Form CMS-1500 paper claim form each test must be submitted on a separate claim form. Treat paper claims submitted with more than one anti-markup test as unprocessable per §80.3.2.

More than one anti-markup test may be billed on the ASC X12 837 professional claim format. When more than one test is billed, the total acquired amount must be submitted for each service. Treat claims received with multiple anti-markup tests without line level total acquired amount information as unprocessable per §80.3.2.

Treat paper claims submitted for anti-markup tests with both the technical component and the professional component on one claim as unprocessable per §80.3.2 unless the services are submitted with the same date of service and same place of service codes. When a claim is received that includes both services, and the date of service and place of service codes match, assume that the one address in Item 32 applies to both services. Effective for claims with dates of service on or after April 1, 2005, each component of the test must be submitted on a separate claim form. Treat paper claims with dates of service after March 31, 2005 submitted with more than one anti-markup test as unprocessable per §80.3.2.

ASC X12 837 professional electronic claims submitted for anti-markup tests with both the technical component and professional component on the same claim must be accepted. Assume that the claim level service facility location information applies to both services if line level information is not provided.

In order to price claims correctly and apply anti-markup payment limitations, global billing is not acceptable for claims received on the Form CMS-1500 or on the ASC X12 837 professional claim format. Each component must be billed as a separate line item (or on a separate claim per the limitations described above). Treat the claim as unprocessable per §80.3.2 when a global billing is received and there is information on the claim that indicates the test was acquired.

Effective for claims with dates of service on or after January 25, 2005, A/B MAC (Part B) must accept and process claims for diagnostic tests subject to the anti-markup payment limitation when billed by suppliers (including laboratories, physicians, and independent diagnostic testing facilities [IDTFs]) enrolled in the A/B MAC (Part B) jurisdiction, regardless of the location where the service was furnished. Effective April 1, 2005, A/B MAC (Part B) must price anti-markup test claims based on the ZIP code of the location where the service was rendered when billed by a laboratory or an IDTF, using a CMS-supplied national abstract file of the MPFS containing the HCPCS codes that are payable under the MPFS as either a technical component or professional component of a diagnostic test subject to the anti-markup payment limitation for the calendar year. Effective for claims with dates of service on or after October 1, 2007 through 2013, A/B MAC (Part B) must use the national abstract file to price all claims for diagnostic tests subject to an anti-markup payment limitation, for all supplier specialty types (including physicians), based on the ZIP code of the location where the service was rendered, in accordance with the A/B MAC (Part B) jurisdictional pricing rules specified in §10.1.1. Beginning in 2014, A/B MAC (Part B) must refer to an Anti-markup Test Indicator linked to the HCPCS code on the MPFS to price all claims for diagnostic tests subject to an anti-markup payment limitation, for all supplier specialty types (including physicians), based on the ZIP code of the location where the service was rendered, in accordance with the A/B MAC (Part B) jurisdictional pricing rules specified in §10.1.1.

NOTE: As with all services payable under the MPFS, the ZIP code is used to determine the appropriate payment locality and corresponding fee for the anti-markup test. When a ZIP code crosses locality lines, CMS uses the dominant locality to determine the corresponding fee.
lines, CMS uses the dominant locality to determine the corresponding fee.

30.2.10 - Payment Under Reciprocal Billing Arrangements - Claims Submitted to A/B MACS Part B

(Rev. 3774, 05-12-17, Effective: 06-13-17, Implementation: 06-13-17)

A. General requirements applicable to all Reciprocal Billing Arrangements

Under section 16006 of the 21st Century Cures Act, a Medicare-enrolled physical therapist may use a substitute physical therapist to furnish outpatient physical therapy services in a HPSA, a MUA, or a rural area under a reciprocal billing arrangement on or after June 13, 2017.

The patient's regular physician or physical therapist may submit the claim, and (if assignment is accepted) receive the Part B payment, for covered visit services which the regular physician or physical therapist arranges to be provided by a substitute physician or physical therapist on an occasional reciprocal basis, if:

- The regular physician or physical therapist is unavailable to provide the services;
- The Medicare patient has arranged or seeks to receive the services from the regular physician or physical therapist;
- The substitute physician or physical therapist does not provide the services to Medicare patients over a continuous period of longer than 60 days subject to the following exception: A physician or physical therapist called to active duty in the Armed Forces may bill for services furnished under a reciprocal billing arrangement for longer than the 60-day limit; and
- The regular physician or physical therapist indicates that the services were provided by a substitute physician or physical therapist under a reciprocal billing arrangement meeting the requirements of this section by entering in item 24d of Form CMS-1500 HCPCS code Q5 modifier (service furnished under a reciprocal billing arrangement by a substitute physician or by a substitute physical therapist furnishing outpatient physical therapy services in a health professional shortage area, a medically underserved area, or a rural area) after the procedure code. The regular physician or physical therapist must keep on file a record of each service provided by the substitute physician or physical therapist along with the substitute physician or physical therapist's NPI, and make this record available to the A/B MAC Part B upon request.

If the only services a physician performs in connection with an operation are post-operative services furnished during the period covered by the global fee, these services need not be identified on the claim as services furnished by a substitute physician.

A physician or physical therapist may have reciprocal billing arrangements with more than one physician or physical therapist. The arrangements need not be in writing.

With respect to physicians, the term "**covered visit service"** includes not only those services ordinarily characterized as a covered physician visit, but also any other covered items and services furnished by the substitute physician or by others as "incident to" the physician's services.

With respect to physical therapists, the term "**covered visit service**" means outpatient physical therapy services furnished in a HPSA, a MUA, or a rural area. HPSAs and MUAs are designated by the Health Resources & Services Administration (HRSA). To determine if an area is a HPSA or an MUA, visit HRSA's website at https://www.hrsa.gov. A rural area is any area that is outside of a Metropolitan Statistical Area or a Metropolitan Division (in the case where a Metropolitan Statistical Area is

divided into Metropolitan Divisions), as defined by the Executive Office of Management and Budget, or the following New England counties: Litchfield County, Connecticut; York County, Maine; Sagadahoc County, Maine; Merrimack County, New Hampshire; and Newport County, Rhode Island. To determine if an area is rural, consult the Crosswalk of Counties to Core-Based Statistical Areas in the most current Inpatient Prospective Payment system final rule. Any area that is not designated as urban in the crosswalk is rural.

A "**continuous period of covered visit services"** begins with the first day on which the substitute physician or physical therapist provides covered visit services to Medicare Part B patients of the regular physician or physical therapist, and ends with the last day the substitute physician or physical therapist provides services to such patients before the regular physician or physical therapist returns to work. This period continues without interruption on days on which no covered visit services are provided to patients on behalf of the regular physician or physical therapist or are furnished by some other substitute physician or physical therapist on behalf of the regular physician or physical therapist. A new period of covered visit services can begin after the regular physician or physical therapist has returned to work.

EXAMPLE: The regular physician or physical therapist goes on vacation on June 30, and returns to work on September 4. A substitute physician or physical therapist provides services to Medicare Part B patients of the regular physician or physical therapist on July 2, and at various times thereafter, including August 30 and September 2. The continuous period of covered visit services begins on July 2 and runs through September 2, a period of 63 days. Since the September 2 services are furnished after the expiration of 60 days of the period, the regular physician or physical therapist is not entitled to bill and receive direct payment for the services furnished August 31 through September 2. The substitute physician or physical therapist must either bill for the services furnished August 31 through September 2 in his/her own name and billing number or reassign payment to the person or group that bills for the services of the substitute physician or physical therapist. The regular physician or physical therapist may, however, bill and receive payment for the services that the substitute physician or physical therapist provides on behalf of the regular physician or physical therapist in the period July 2 through August 30.

The requirements for the submission of claims under reciprocal billing arrangements are the same for assigned and unassigned claims.

A/B MACs Part B should inform physicians and physical therapists of the compliance requirements when billing for services of a substitute physician or physical therapist. The physician or physical therapist notification should state that, in entering the Q5 modifier, the regular physician or physical therapist (or the medical group or physical therapy group, where applicable) is certifying that the services are covered visit services furnished by the substitute physician or physical therapist identified in a record of the regular physician or physical therapist which is available for inspection, and are services for which the regular physician or physical therapist (or group) is entitled to submit the

claim. A/B MACs Part B should include in the notice that penalty for false certifications may include civil or criminal penalties for fraud, or administrative penalties including revocation of the physician's or physical therapist's Medicare billing privileges, right to receive payment, or to submit claims or accept any assignments. The revocation procedures are set forth under 42 CFR 424.535 and in the Medicare Program Integrity Manual (Pub. 100-8).

If a line item includes the code Q5 certification, A/B MACs Part B assume that the claim meets the requirements of this section in the absence of evidence to the contrary. A/B MACs Part B need not track the 60-day period or validate the billing arrangement on a prepayment basis, absent postpayment findings that indicate that the Q5 certifications by a particular regular physician or physical therapist may not be valid.

When A/B MACs Part B make Part B payment under this section, they determine the payment amount as though the regular physician or physical therapist provided the services. The identification of the substitute physician or physical therapist is primarily for purposes of providing documentation to verify upon audit that the services were actually furnished, not for purposes of the payment or the limiting charge. Also, notices of noncoverage are to be given in the name of the regular physician or physical therapist.

B. Requirements applicable to Physician Medical Group or Physical Therapy Group Claims Under Reciprocal Billing Arrangements

In order for a medical group or physical therapy group to submit claims in the name of the regular physician or physical therapist for the services of a substitute physician or physical therapist, the substitute physician or physical therapist may not have reassigned his or her right to Medicare payment to the group through a CMS-855R reassignment enrollment form approved by the A/B MACs Part B and the following requirements must be met:

- The regular physician or physical therapist is unavailable to provide the services;
- The Medicare patient has arranged or seeks to receive the services from the regular physician or physical therapist; and
- The substitute physician or physical therapist does not provide the services to Medicare patients over a continuous period of longer than 60 days subject to the following exception: A physician or physical therapist called to active duty in the Armed Forces may bill for services furnished under a reciprocal billing arrangement for longer than the 60-day limit.

Services are billed for the entity as follows:

- The medical group or physical therapy group must enter in item 24d of Form CMS-1500 the HCPCS code modifier Q5 after the procedure code.

- The designated attending physician for a hospice patient (receiving services related to a terminal illness) bills the Q5 modifier in item 24 of Form CMS-1500 when another group member covers for the attending physician.

- A record of each service provided by the substitute physician or physical therapist must be kept on file along with the substitute physician's or physical therapist's NPI. This record must be made available to the A/B MAC Part B upon request.

- In addition, the medical group physician or group physical therapist on whose behalf the services were furnished by a substitute must be identified by his/her NPI in block 24J of the appropriate line item.

On claims submitted by a group, the group physician or group physical therapist who actually performed the service must be identified in the manner described in §30.2.13, with one exception. When a group member provides services on behalf of another group member who is the designated attending physician for a hospice patient, the Q5 modifier may be used **by the designated attending physician** to bill for services related to a hospice patient's terminal illness that were performed by another group member.

30.2.11 - Payment Under Fee-For-Time Compensation Arrangements (formerly referred to as Locum Tenens Arrangements) - Claims Submitted to A/B MACs Part B

(Rev. 3774, 05-12-17, Effective:06-13-17, Implementation: 06-13-17)

A. Background

It is a longstanding practice for a physician to retain a substitute physician to take over his/her professional practice when the physician is absent for reasons such as illness, pregnancy, vacation, or continuing medical education, and for such physician (the regular physician) to bill and receive payment for the substitute physician's services as though he/she performed them. The substitute physician often has no practice of his/her own and may move from area to area as needed. The regular physician generally pays the substitute physician on a per diem or other fee-for-time compensation basis with the substitute physician having the status of an independent contractor, rather than of an employee, of the regular physician.

A regular physician or physical therapist is the physician or physical therapist who is normally scheduled to see a patient. A regular physician may include a physician specialist (such as a cardiologist, oncologist, urologist, hospitalist, etc.).

Under section 16006 of the 21st Century Cures Act, a Medicare-enrolled physical therapist may use a substitute physical therapist to furnish outpatient physical therapy services in a HPSA, a MUA, or a rural area under a fee-for-time compensation arrangement on or after June 13, 2017.

B. General requirements applicable to all Fee-For-Time Compensation Arrangements

A patient's regular physician or physical therapist may submit the claim, and (if assignment is accepted) receive the Part B payment, for covered visit services of a substitute physician or physical therapist, if:

- The regular physician or physical therapist is unavailable to provide the services;
- The Medicare beneficiary has arranged or seeks to receive the services from the regular physician or physical therapist;
- The regular physician or physical therapist pays the substitute for his/her services on a per diem or similar fee-for-time basis;
- The substitute physician or physical therapist does not provide the services to Medicare patients over a continuous period of longer than 60 days subject to the following exception: A physician or physical therapist called to active duty in the Armed Forces may bill for services furnished under a fee-for-time compensation arrangement for longer than the 60-day limit; and
- The regular physician or physical therapist indicates that the services were provided by a substitute physician or physical therapist under a fee-for-time compensation arrangement meeting the requirements of this section by entering HCPCS code modifier Q6 (service furnished under a fee-for-time compensation arrangement by a substitute physician or by a substitute physical therapist furnishing outpatient physical therapy services in a health professional shortage area, a medically underserved area, or a rural area) after the procedure code.

If the only services a physician performs in connection with an operation are post-operative services furnished during the period covered by the global fee, these services need not be identified on the claim as services furnished by a substitute physician.

With respect to physicians, the term "**covered visit service"** includes not only those services ordinarily characterized as a covered physician visit, but also any other covered items and services furnished by the substitute physician or by others as "incident to" the physician's services.

With respect to physical therapists, the term "**covered visit service**" means outpatient physical therapy services furnished in a HPSA, a MUA, or a rural area. HPSAs and MUAs are designated by HRSA. To determine if an area is a HPSA or an MUA, visit HRSA's website at https://www.hrsa.gov. A rural area is any area that is outside of a Metropolitan Statistical Area or a Metropolitan Division (in the case where a Metropolitan Statistical Area is divided into Metropolitan Divisions), as defined by the Executive Office of Management and Budget, or the following New England counties: Litchfield County, Connecticut; York County, Maine; Sagadahoc County, Maine; Merrimack County, New Hampshire; and Newport County, Rhode Island. To determine if an area is rural, consult the Crosswalk of Counties to Core-Based Statistical Areas in

the most current Inpatient Prospective Payment system final rule. Any area that is not designated as urban in the crosswalk is rural.

A "**continuous period of covered visit services"** begins with the first day on which the substitute physician or physical therapist provides covered visit services to Medicare Part B patients of the regular physician or physical therapist, and ends with the last day the substitute physician or physical therapist provides services to such patients before the regular physician or physical therapist returns to work. This period continues without interruption on days on which no covered visit services are provided to patients on behalf of the regular physician or physical therapist or are furnished by some other substitute physician or physical therapist on behalf of the regular physician or physical therapist. A new period of covered visit services can begin after the regular physician or physical therapist has returned to work.

EXAMPLE: The regular physician or physical therapist goes on vacation on June 30, and returns to work on September 4. A substitute physician or physical therapist provides services to Medicare Part B patients of the regular physician or physical therapist on July 2, and at various times thereafter, including August 30 and September 2. The continuous period of covered visit services begins on July 2 and runs through September 2, a period of 63 days. Since the September 2 services are furnished after the expiration of 60 days of the period, the regular physician or physical therapist is not entitled to bill and receive direct payment for the services furnished August 31 through September 2. The substitute physician or physical therapist must either bill for the services furnished August 31 through September 2 in his/her own name and billing number or reassign payment to the person or group that bills for the services of the substitute physician or physical therapist. The regular physician or physical therapist may, however, bill and receive payment for the services that the substitute physician or physical therapist provides on behalf of the regular physician or physical therapist in the period July 2 through August 30.

The requirements for the submission of claims under fee-for-time compensation arrangements are the same for assigned and unassigned claims.

A/B MACs Part B should inform physicians and physical therapists of the compliance requirements when billing for services of a substitute physician or physical therapist. The physician/physical therapist notification should state that, in entering the Q6 modifier, the regular physician or physical therapist (or the medical group or physical therapy group, where applicable) is certifying that the services are covered visit services furnished by the substitute physician or physical therapist identified in a record of the regular physician or physical therapist which is available for inspection, and are services for which the regular physician or physical therapist (or group) is entitled to submit the claim. A/B MACs Part B should include in the notice that penalty for false certifications may include civil or criminal penalties for fraud, or administrative penalties including revocation of the physician's or physical therapist's Medicare billing privileges, right to receive payment, or to submit claims or accept any assignments. The revocation procedures are set forth under 42 CFR 424.535 and in the Medicare Program Integrity Manual (Pub. 100-8).

If a line item includes the code Q6 certification, A/B MACs Part B assume that the claim meets the requirements of this section in the absence of evidence to the contrary. A/B MACs Part B need not track the 60-day period or validate the billing arrangement on a prepayment basis, absent postpayment findings that indicate that the Q6 certifications by a particular regular physician or physical therapist may not be valid.

When A/B MACs Part B make Part B payment under this section, they determine the payment amount as though the regular physician or physical therapist provided the services. The identification of the substitute physician or physical therapist is primarily for purposes of providing documentation to verify upon audit that the services were furnished, not for purposes of the payment or the limiting charge. Also, notices of noncoverage are to be given in the name of the regular physician or physical therapist.

C. Requirements applicable to Physician Medical Group or Physical Therapy Group Claims Under Fee-For-Time Compensation Arrangements

In order for a medical group or physical therapy group to submit claims in the name of the regular physician or physical therapist for the services of a substitute physician or physical therapist, the substitute physician or physical therapist may not have reassigned his or her right to Medicare payment to the group through a CMS-855R reassignment enrollment form approved by the A/B MACs Part B and the following requirements must be met:

- The regular physician or physical therapist is unavailable to provide the services;
- The Medicare patient has arranged or seeks to receive the services from the regular physician or physical therapist; and
- The substitute physician or physical therapist does not provide the services to Medicare patients over a continuous period of longer than 60 days subject to the following exception: A physician or physical therapist called to active duty in the Armed Forces may bill for services furnished under a fee-for-time compensation arrangement for longer than the 60-day limit.

For purposes of these requirements, per diem or similar fee-for-time compensation which the group pays the substitute is considered paid by the regular physician or physical therapist. Also, a physician or physical therapist who has left the group and for whom the group has engaged a substitute as a temporary replacement may bill for the temporary physician or physical therapist for up to 60 days. The term “regular physician or physical therapist” includes a physician or physical therapist who has left the group and for whom the group has hired the substitute as a replacement.

Services are billed for the entity as follows:

- The medical group or physical therapy group must enter in item 24d of Form CMS-1500 the HCPCS code modifier Q6 after the procedure code.

- The designated attending physician for a hospice patient (receiving services related to a terminal illness) bills the Q6 modifier in item 24 of Form CMS-1500 when another group member covers for the attending physician.

- A record of each service provided by the substitute physician or physical therapist must be kept on file along with the substitute physician's or physical therapist's NPI. This record must be made available to the A/B MACs Part B upon request.

- In addition, the medical group physician or group physical therapist on whose behalf the services were furnished by a substitute must be identified by his/her NPI in block 24J of the appropriate line item.

30.2.12 - Establishing That a Person or Entity Qualifies to Receive Payment on Basis of Reassignment - for Carrier Processed Claims

(Rev. 1, 10-01-03)
B3-3060.8

Any person or entity wishing to receive Part B payment as a reassignee of one or more physicians (or other practitioner or supplier), or as the supplier of the services, must furnish to the carrier sufficient information to establish clearly that it qualifies to receive payment for those services. Where there is any doubt that the person or entity qualifies, the carrier must obtain additional evidence.

In some cases, an entity may qualify to receive payment for the services of a physician on the basis of one or more of the exceptions listed in §30.2. As soon as it is determined that an organization can qualify on any basis, no further development may be needed for that physician or for other physicians having the same status. However, where some other physicians have or appear to have different status, further development is required. In some cases a determination is made that Part B payment can be made only to the physician.

Subject to the provisions of §§30, a reassignee assumes liability for any overpayments that it receives and should be so advised.

A. Payment to Special Accounts

Sometimes a major institution, such as a medical school or university, may want the Medicare checks due it for physician services to go into particular specialty accounts (or funds, or so-called group practices) which are subdivisions of the institution, and may ask that these accounts be identified on their Medicare checks for internal accounting purposes.

Ideally, to indicate the subordinate nature of the account in relation to the institution, carriers list the name of the institution first on the check, followed by the name of the appropriate account. However, identifying the payee in this manner may cause serious claims processing difficulties, fostering confusion between various accounts of the same institution. To avoid this problem, carriers may list the name of the account first, followed by the name of the institution, e.g., Radiology Fund or General Medical Center, if the institution submits a letter accepting responsibility for any claims submitted, and payments made, under the special designations. The letter needs to describe the special designations the institution wants on the checks for the various accounts and include a statement to the following effect:

> The (name of institution) accepts the same responsibility for the Medicare claims and payments made under these special designations as it would have if the payments were made by Medicare in the name of (name of institution) without these special designations.

This statement is required in addition to the statement the institution submits to establish its right to receive payment for the physicians' services.

If the above procedure is used as a basis for Part B payments in the names of departments, specialties, or similar subdivisions of a university or medical school or an associated nonprofit foundation or teaching hospital, each subdivision may also execute, or refrain from executing, a participation agreement for physician services in that subdivision. This is an exception to the rule that a participation agreement may only be executed by a person or legal entity. This exception applies only in the medical school or university medical center context.

30.2.13 - Billing Procedures for Entities Qualified to Receive Payment on Basis of Reassignment - for A/B MAC Part B Processed Claims

(Rev. 3774, 05-12-17, Effective: 06-13-17, Implementation: 06-13-17)

Except where otherwise noted, the following procedures apply to both assigned and unassigned claims submitted by medical groups and other entities entitled to bill and receive payment for physician services under §§30.2-30.2.8. They are used whether the charges are compensation related or non-compensation related.

A General

Chapter 26 contains general claims processing instructions. A medical group, or other entity entitled to bill and receive payment for physician services uses the current ASC X12 professional claim billing format or Form CMS-1500 to submit claims to Medicare A/B MACs Part B. A single claim form may contain services furnished to the same patient by different physicians associated with the same entity. The name and address of the entity is entered in block 33 of Form CMS-1500 or in the corresponding ASC X12 837 location. For paper claims an authorized official of the entity signs in block 31. This official need not be a physician. For electronic claims a certification can be maintained

on file. (See CMS EDI Web page (http://www.cms.hhs.gov/providers/edi/edi3.asp) for electronic billing formats.)

B Provider Identification Numbers

The entity's NPI, when required, is entered in block 33a. Each physician who performs services for a patient must be identified on the Form CMS-1500 claim in block 24J for the appropriate line item in accordance with instructions in the Medicare Program Integrity Manual. (When an entity bills for an independent substitute physician or physical therapist under a reciprocal or fee-for-time compensation substitute billing arrangement, the "performing" physician or physical therapist identified on the claim form is the regular physician or regular physical therapist who is a member of the entity.)

C Payment Records

Where the charges by a hospital, medical group, or other entity differ depending on the individual treating physician, A/B MACs Part B transmit the performing physician's NPI when required on the Common Working File (CWF) claim record. Where the charges by a hospital, medical group, or other entity are uniform regardless of the individual performing physician, claims records are prepared by entity and entity identification numbers rather than by individual physician and individual physician identification numbers. Show code 70 as specialty code on claims records where such entity's physicians have mixed (more than one) specialties. Where all the physicians associated with such entity have the same specialty, the code used reflects the specialty, e.g., code 30 for a group of radiologists, code 11 for a group of internists.

D Outpatient Physical Therapy or Speech-Language Pathology Claims
Clinics that have been certified to provide outpatient physical therapy or speech-language pathology services to outpatients also use the ASC X12 837 professional claim format, or the CMS-1500 claim form for billing the A/B MAC Part B.

30.2.14 - Correcting Unacceptable Payment Arrangements
(Rev. 3774, 05-12-17, Effective: 06-13-17, Implementation: 06-13-17)

A. Disseminating Information

From time to time, A/B MACs must disseminate through professional relations media information regarding the prohibition in §30.2.

A/B MACs Part A

The following language may be used by A/B MACs Part A or adapted for this purpose: The Medicare law prohibits us from paying benefits due a provider to another person or organization under an assignment, power of attorney, or any other arrangement whereby that other person or organization receives those payments directly. There are the following exceptions to this rule:

- CMS may pay a provider's benefits (in the provider's name) to a billing or collection agent, if:

  - The agent receives the payment under an agency agreement with the provider;
  - The agent's compensation is not related in any way to the dollar amounts billed or collected;
  - The agent's compensation is not dependent upon the actual collection of payment;
  - The agent acts under instructions which the provider may modify or revoke at any time; and
  - The agent, in receiving payment, acts only in the providers' behalf.

- CMS may pay the providers' benefits in accordance with an assignment established by, or pursuant to the order of, a court of competent jurisdiction.

A provider should notify us immediately if:

- CMS has been mailing its benefits to the address of another person or organization;

- The provider has given that other person or organization power of attorney or other advance authority to negotiate its benefit checks; and

- None of the above exceptions that would permit payment to another person or organization apply in the provider's case.

A provider which hereafter enters into or continues such a prohibited payment arrangement may have its participation in the program terminated and its right to receive assigned payment for physician services revoked.

A/B MACs Part B and DME MACs

An A/B MAC Part B and DME MAC may use or adapt the following language for notification:

The Medicare law prohibits us from paying benefits due a physician or other supplier of health care items and services, to another person or organization, under a reassignment or power of attorney or under any other arrangement whereby that other person or organization receives those payments directly. There are the following exceptions to this rule:

- CMS may pay a physician's or supplier's employer under the terms of his/her employment.

- CMS may pay a hospital, clinic, or other facility for services furnished by the physician or supplier in the facility, in accordance with the physician's or supplier's agreement with the facility.

- CMS may pay a group practice prepayment plan, prepaid health plan, or

- HMO for services of physicians and suppliers associated with the plan.

- CMS may pay a physician, medical group, or other supplier for the technical component (TC) or professional component (PC) of diagnostic tests (other than clinical diagnostic tests) that are subject to the anti-markup payment limitation.

- CMS may pay the patient's regular physician or physical therapist for services provided to his/her patients by another physician or physical therapist on an occasional, reciprocal basis

- CMS may pay the patient's regular physician or physical therapist for services of a substitute physician or physical therapist during the absence of the regular physician or physical therapist where the regular physician or physical therapist pays the substitute on a per diem or similar fee-for-time basis.

- CMS may pay a physician's or supplier's benefits in his/her name to a billing or collection agent, e.g., a medical bureau, if:

    - The agent receives the payment under an agency agreement with the physician or supplier;
    - The agent's compensation is not related in any way to the dollar amounts billed or collected;
    - The agent's compensation is not dependent upon the actual collection of payment;
    - The agent acts under instructions which the physician or supplier may modify or revoke at any time; and
    - The agent, in receiving the payment, acts only on the physician's or supplier's behalf.

- CMS may pay a physician's or supplier's benefits in accordance with a reassignment established by, or pursuant to the order of, a court of competent jurisdiction.

A physician or supplier should notify us immediately if:

- CMS has been mailing his/her benefits to the address of another person or organization;

- The physician has given that other person or organization power of attorney or other advance authority to negotiate the physician's benefit checks; and

- None of the above exceptions which would permit payment to another person or organization apply in his/her case.

A physician or other eligible recipient of assigned payment who hereafter enters into or continues such a prohibited payment arrangement may have the right to receive assigned payment revoked.

30.2.14.1 - Questionable Payment Arrangements
(Rev. 1, 10-01-03)

A. Developing Questionable Payment Arrangements

Contractors (both FIs and Carriers) should assume that an arrangement in which Medicare payment is being sent or is to be sent to an address other than the physical location of the provider/supplier is consistent with the requirements of §30.2 in the absence of evidence to the contrary. However, develop the facts of any case in which:

- The contractor becomes aware that it is mailing or asked to mail the provider/supplier's payments to the address of another person or organization; **and**

- It is likely the other person or organization is not qualified to receive payments under one of the exceptions in §30.2.1 or is a financial institution. (See §30.2.5.)

Contractors must develop the facts of the case, e.g., where it appears that the contractor is mailing or asked to mail the provider provider/supplier's payments to the address of a company known to be engaging in factoring.

B. How to Develop Questionable Payment Arrangements

Discretion must be used in determining the procedure to follow in developing questionable payment arrangements. Contractors should ascertain the reason for the special address. Once it is determined that payments due the provider/supplier are being made to another party (although in the name of the provider), the contractor must ascertain whether any of the exceptions in §30.2.1 apply. After initial contact with the provider/supplier, the contractor may find the other party to be the best source of information about the arrangement. The contractor should establish the crucial elements of the arrangement by obtaining a copy of the formal agreement, if any, between the parties, copies of pertinent correspondence, and/or signed statements of the parties. The

failure of the provider/supplier to cooperate in furnishing the necessary information (or in giving any necessary authorization for others to furnish information) is grounds (see §30.2.15) for terminating the provider/supplier's participation in the program and revoking its right to receive assigned payment.

C. Change of Address

If the contractor determines that a person or organization is ineligible to receive payments due a provider/supplier, routinely mailing the provider/supplier's payments to that person or organization's address should be discontinued. However, such a mailing address is acceptable if:

- The parties to the arrangement have given written assurances that the person or organization to whose address the check is mailed will not convert the check to its own use and control, or if the organization is a financial institution, that the requirements of §30.2.5 are met; and

- The purpose of the arrangement makes the assurances credible.

An acceptable mailing arrangement could exist, e.g., when the provider/supplier wants its checks mailed for bookkeeping purposes to a business agent who is ineligible to receive the payment, and both the agent and the provider state in writing that the agent will forward the checks to the provider's bank for deposit in a business account from which the provider/supplier is free to withdraw any deposited funds.

D. Reviewing Endorsements on Checks

In any case where the contractor, after developing the facts, continues to mail the provider's payments to an address which may be that of another person, but still doubts that the arrangement is inconsistent with these instructions, review (after a reasonable interval) endorsements on the returned checks for indications that the checks are being negotiated under a power of attorney. When someone negotiates a provider/supplier's checks under a power of attorney, the provider/supplier's name is typically printed on the back of the check with the endorsee's signature below, followed by "p.p." or "p.p.a." or "p.o.a" (for per procuration, per power of attorney, or power of attorney).

30.2.15 - Sanctions for Prohibited Payment Arrangement

(Rev. 1, 10-01-03)
A3-3488.4, B3-3060.13, B3-3060.14

A. Advice to Provider

If the contractor finds that a provider (for Part B, physician or other supplier, or party eligible to receive the payment under §30.2 as an employer, facility or organization) has entered into, or is considering entering into, a payment arrangement prohibited by §30.2, the contractor must advise that provider in writing that the arrangement violates Medicare

law and regulations and subjects the provider to the penalties described in subsections B and C. When the improper payment arrangement is in effect, the contractor must require a change in the address to which the provider's checks are sent. For an exception, see §30.2.14.1C.

B. Bases for Termination of a Provider's Medicare Participation Agreement

The CMS may terminate a provider's Medicare participation agreement if the provider/physician:

- Executes or continues an assignment or a power of attorney, or enters into or continues any other arrangement, that authorizes or permits Medicare cost-basis payments to be made contrary to §§30.2, 42 CFR 405.1668, and §1815(c) of the Act after having been advised under subsection A above; or

- Fails to furnish upon request by CMS or the contractor such information as CMS or the contractor finds necessary to establish compliance with the requirements of this section.

The provider has the usual appeal rights applicable to agreement termination determinations.

C. Bases for Revocation of Assignment Privilege

The CMS may revoke the right of a provider to receive assigned payment for physician services if the provider:

- Executes or continues a reassignment or power of attorney, or enters into or continues any other arrangement, that authorizes or permits Medicare charge basis payments to be made contrary to §§30.2, 42 CFR 405.1680, and §1842(b)(6) of the Act, after CMS or the carrier gives the provider advice about such violation;

- Fails to furnish upon request by CMS or the carrier evidence needed to establish compliance with the requirements of §§30.2, 42 CFR 405.1680, and §1842(b)(6) of the Act;

- Violates the terms of assigned payment; e.g., by collecting or attempting to collect more than the allowable amount, after CMS or the carrier gives the provider advice about such violations; or

- Fails to desist from collection efforts already begun, or to refund monies incorrectly collected, in violation of the terms of assigned payment, after CMS or the carrier gives the provider instructions to cease to take such action.

A special appeals procedure is provided within CMS when action is taken to revoke a provider's right to accept assignment.

The fact that a provider's right to accept assignment is revoked does not preclude it from billing the beneficiary for the services or changing its arrangement with the physician to permit billing for rendered services, either on an assigned or unassigned basis. On the other hand, a provider is not ordinarily precluded from accepting assignment from a beneficiary for the services of a physician whose assignment privilege has been revoked if the beneficiary has an agreement with the provider giving it the right to bill for services rendered. There is an exception. The revocation of a physician's assignment privilege automatically revokes the assignment privilege of any corporation, partnership, or other entity in which the provider/supplier directly or indirectly has or obtains all or all but a nominal part of the financial interest. Such entity may not accept assignment for the services of the physician or anyone else. What is a nominal interest depends upon the circumstances. The contractor may assume that an interest by other persons totaling at least five percent of the financial interest of the entity is more than nominal. The term "indirect interest" refers to the situation where the entity billing for the physician's services is owned by another entity in which the physician has most of the financial interest.

D. Action When Violations Are Found

When the contractor finds that the provider/supplier has, after warning to the contrary, entered into, or continued, a prohibited payment arrangement, failed to cooperate in furnishing the information necessary to resolve the issue, violated its assignment agreement or failed to correct a violation of its assignment agreement, the contractor forwards a copy of the file to the program integrity staff in the RO. The RO considers whether further development of the facts or admonition of the provider will be useful before taking steps to terminate its participation agreement and/or to revoke its right to accept assignment.

In imposing the administrative sanction of revocation of the assignment privilege, the RO notifies the provider/supplier of the proposed revocation of its right to receive assigned benefits and gives it 15 days in which to submit a statement, including any pertinent evidence, explaining why its right to payment should not be revoked. After the statement has been submitted, or the 15-day period has expired without the filing of the statement, the RO determines whether to revoke the provider/supplier's right to receive assigned payment. If its determination is to revoke, the RO notifies the contractor to suspend payment on all assigned claims submitted by the provider/supplier and received after the effective date of the revocation. It notifies the provider/supplier of the revocation and of its right to request a hearing on the revocation within 60 days. (The RO may extend the period for requesting a hearing.)

If the provider/supplier requests a formal hearing (to be conducted by a member of the hearings staff of CMS) and the hearing officer reverses the revocation determination, the RO instructs the carrier and FI to pay the provider/supplier 's assigned claims (the physician component). If the hearing officer upholds the revocation determination or if no request for a hearing is filed during the period allowed for this, the RO instructs the

carrier and FI to make any assigned payments otherwise due the provider to the beneficiary who received the services, or another person or agency authorized under the law and regulations to receive the payments (e.g., the beneficiary's legal guardian or representative payee or, if the beneficiary is deceased, the person who paid the bill). The revocation remains in effect until the RO finds that the reason for the revocation has been removed and that there is reasonable assurance that it will not recur. The RO decision to continue the revocation in effect may not be appealed.

The law provides that any person who accepts assignment of benefits under Medicare and who "knowingly, willfully, and repeatedly" violates the assignment agreement shall be guilty of a misdemeanor and subject to a fine of not more than $2000 or imprisonment of not more than six months or both. The RO may invoke the administrative sanction in appropriate cases to deny payment while criminal prosecution is being considered or in process, or, as an alternative, when prosecution is inappropriate or not feasible. Since this sanction may in some cases interfere with effective prosecution, imposition of the sanction is discretionary rather than mandatory.

30.2.16 - Prohibition of Assignments by Beneficiaries
A3-3488.5, B3-3060.15, B3-7065 partial

A. Basic Prohibition

Except as provided in subsection B, carriers pay only the beneficiary (or beneficiary legal representative or representative payee) benefits payable directly to the beneficiary FIs do not send money directly to beneficiaries, they must require providers they pay to refund monies to beneficiaries when circumstances so warrant (i.e., when a provider has collected money from a beneficiary for a demand-billed service that is later found to be covered by Medicare). This prohibition does not, of course, apply to payment under an assignment of benefits by the beneficiary to the physician or other supplier who furnished the services or to a qualified reassignee, e.g., a hospital.

B. Exceptions

- Payment to a Government Agency. The law does not preclude the Medicare program from paying the benefits due a beneficiary to a governmental agency or entity. However, see §30.2.1 for the effect of the requirements of the Assignment of Claims Act.

- Payment Pursuant to Court Order. The Medicare program may make payment of amounts due a beneficiary, in accordance with an assignment established by, or pursuant to the order of, a court of competent jurisdiction. The assignment must satisfy the conditions in §§30.2.

- Payment to Agent. The Medicare program may make payment in the name of the provider to an agent who furnishes billing or collection services. The payment arrangement between the provider and an agent must meet the same requirements

as the payment arrangement between a physician and an agent. (See §30.2.4 for payment to an agent of a physician.)

- Indirect Payment. A carrier may make payment of amounts due a beneficiary to an entity which:

    - Provides coverage of the service under a health benefits plan but only to the extent that payment is not made under Part B (i.e., the coverage which the plan provides is complementary to Medicare and covers only the amount by which the Part B payment falls short of the charge approved under the plan for the service);

    - Pays the person who provided the service (or his/her reassignee under §§30.2.6 - 30.2.8) an amount (including the Part B benefit) which that person accepts as full payment; or

    - Has the written authorization of the beneficiary (or beneficiary representative) to receive the Part B payment.

30.3 - Physician/Practitioner/Supplier Participation Agreement and Assignment - Carrier Claims

(Rev. 1035, Issued: 08-18-06, Effective: 07-01-06, Implementation: 09-18-06)

Institutional providers (those that bill Fiscal Intermediaries (FIs)) are paid direct by the FI. In contrast, physicians, practitioners, and suppliers that bill the carrier may choose to enter into a participation agreement.

Carrier "Participating Providers" are paid at 100 percent of the physician fee schedule and must accept assignment (must accept program payment as payment in full, except for any unmet deductible and coinsurance). "Non-participating providers" are paid at 95 percent of the physician fee schedule and may accept assignment on a claim-by-claim basis.

Physicians and suppliers enrolled in the Medicare program under the Form CMS-855 process do not have to sign a "Medicare Participating Physician or Supplier Agreement" in order to bill Medicare and receive payment. However, there is a 5 percent reduction in the Medicare approved amounts if the physician or his/her reassignee does not participate. Participation is an election that is optional to suppliers, even those that have to bill assigned.

Also, regardless of participation, some suppliers and practitioner types are required to accept assignment. This is covered in the instructions in later chapters for each service type.

30.3.1 - Mandatory Assignment on Carrier Claims

(Rev. 12448; Issued:01-11-24; Effective: 01-01-24; Implementation: 02-12-24)

The following practitioners who provide services under the Medicare program are required to accept assignment for all Medicare claims for their services. This means that they must accept the Medicare allowed amount as payment in full for their practitioner services. The beneficiary's liability is limited to any applicable deductible plus the 20 percent coinsurance.

Assignment is mandated for the following claims:

- Clinical diagnostic laboratory services and physician lab services;
- Physician services to individuals dually entitled to Medicare and Medicaid;

Services of physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives, certified registered nurse anesthetists, clinical psychologists, clinical social workers, marriage and family therapists, mental health counselors, registered dietitians/nutritionists, anesthesiologist assistants, and mass immunization roster billers.

NOTE: The provider type Mass Immunization Roster Biller can only bill for influenza and pneumococcal vaccinations and administrations. These services are not subject to the deductible or the 20 percent coinsurance.

- Ambulatory surgical center services; (No deductible and 25% coinsurance for colorectal cancer screening colonoscopies {G0105 and G0121) and effective for dates of service on or after January 1, 2008 G0104 also applies);

- Home dialysis supplies and equipment paid under Method II for dates of service prior to January 1, 2011. Refer to Section 30.3.8 for information regarding the elimination of Method II home dialysis for dates of service on and after January 1, 2011;

- Drugs and biologicals; and,

- Ambulance services

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

Note that, unlike physicians, practitioners, or suppliers bound by a participation agreement, practitioners/entities providing the services/supplies identified above are required to accept assignment only with respect to these services/supplies (unless they have signed participation agreements which blanket the full range of their services).

The carrier system must be able to identify (and update) the codes for those services subject to the assignment mandate.

For the practitioner services of physicians and independently practicing physical and occupational therapists, the acceptance of assignment is not mandatory. Nor is the acceptance of assignment mandatory for the suppliers of radiology services or diagnostic tests. However, these practitioners and suppliers may nevertheless voluntarily agree to participate to take advantage of the higher payment rate, in which case the participation status makes assignment mandatory for the term of the agreement. Such an agreement is known as the Medicare Participating Physician or Supplier Agreement. (See §30.3.12.2 Carrier Participation Agreement.) Physicians, practitioners, and suppliers who sign this agreement to participate are agreeing to accept assignment on all Medicare claims. The Medicare Participation Agreement and general instructions are on the CMS Web site.

Future updates to this section will be communicated in a Recurring Update Notification.

30.3.1.1 - Processing Claims for Services of Participating Physicians or Suppliers

(Rev. 3510, Issued: 04-29-16, Effective: 10-01-16, Implementation; 10-03-16)

The participating physician or supplier submits any claims for services furnished by the physician or supplier, except in the limited circumstances specified in §30.2.8.3 or §30.2.16. (The exception concerns situations where the physician or supplier accepts, as full payment, payment by certain organizations.) When an unassigned claim is received from a physician, the A/B MAC (B) must verify that the physician is participating. The contractor processes the claim as assigned absent clear evidence of intent by the physician or beneficiary not to assign.

Any Form CMS-1500 claim where the participating physician or supplier checks either the assignment or non-assignment block or fails to check either block, the A/B MAC (B) must treat it as assigned.

Where there is evidence of clear intent not to assign, the A/B MAC (B) must deny the claim. Use MSN 16.6.

> "This item or service cannot be paid unless the provider accepts assignment.

In Spanish:

> "Este artículo o servicio no se pagará a menos de que el proveedor acepte asignación."

A/B MAC (B) must identify and track assignment violations in the event sanctions must be imposed.

No Part B payment is made on a claim by a participating physician or supplier to anyone other than the physician or supplier (except in the case of court-ordered assignment to other parties under §30.2) even if the beneficiary has paid part of the bill. However, if the physician or supplier collects any charges from the beneficiary before submitting the claim, he/she must show on the claim form the amount collected. The carrier refunds directly to the beneficiary, to the extent feasible, any over collection of deductible and coinsurance. The physician is responsible for refunding to the beneficiary any over collection not refunded by the carrier directly. In these latter instances, the carrier advises the physician of his/her obligation to refund any over collections to the beneficiary. Also, the carrier advises the beneficiary of the amount of any refund due from the physician.

30.3.2 - Nature and Effect of Assignment on Carrier Claims

(Rev. 643, Issued: 08-12-05, Effective: 01-01-05, Implementation: 11-14-05)

Assignment is a written agreement between beneficiaries, their physicians or other suppliers, and Medicare. The beneficiary agrees to let the physician or other supplier request direct payment from Medicare for covered Part B services, equipment, and supplies by assigning the claim to the physician or supplier. The physician/supplier in return agrees to accept the Medicare allowed payment amount by the carrier as his/her full charge for the items or services. A physician/supplier who agrees to accept assignment on all claims for Medicare services, rather than on a claim-by-claim basis is known as a participating physician/supplier. See Publication 100-4, chapter 1, sections 30.3 and 30.3.12.2 of the IOM. In effect, the physician/supplier who accepts assignment on a claim-by-claim basis or who is a participating physician/supplier is precluded from charging the enrollee more than the deductible and coinsurance based upon the approved payment amount determination. If dissatisfied with the amount of the Medicare allowed amount, a physician/supplier may follow the procedures for appeals of contractor initial determinations.

In "mandatory assignment" situations, i.e., where payment under the Act can be made only on an assignment-related basis or where payment is for services furnished by a participating physician or supplier, the beneficiary (or the person authorized to request payment on the beneficiary's behalf) is not required to assign the claim to the physician or supplier in order for an assignment to be effective. However, the beneficiary (or the person authorized to request payment on the beneficiary's behalf) must continue to authorize the release of medical or other information necessary to process the claim and request payment of Medicare benefits for the Medicare Part B covered services, equipment, or supplies pursuant to 42 C.F.R 424.32 and 424.36 (see also Pub. 100-04, ch. 1, sect. 50.1). Physicians or suppliers who agree to (or must by law) accept assignment from Medicare cannot attempt to collect more than the appropriate Medicare deductible and coinsurance amounts from the beneficiary, his/her other insurance, or anyone else.

In situations where mandatory assignment is not applicable and a nonparticipating physician or supplier indicates on the claim that he/she accepts assignment, but the beneficiary does not assign the claim to that nonparticipating physician/supplier--payment must be made on an unassigned basis (i.e., directly to the beneficiary).

A violation of the assignment occurs if the physician/supplier collects (or attempts to collect) from the enrollee or anyone else any amount which, when added to the benefit, exceeds the Medicare allowed amount. A bill for assigned services is considered paid in full when the Medicare allowed amount is paid. The carrier payment determination takes into account all of the services furnished by the physician/supplier in connection with the claim. Therefore, a physician/supplier may not charge the enrollee for paperwork involved in filing an assigned claim.

If the enrollee has private insurance in addition to Medicare, the physician/supplier who has accepted assignment of SMI benefits is in violation of his/her assignment agreement if he/she bills or collects from the enrollee and/or the private insurer an amount which, when added to the Medicare benefit received, exceeds the Medicare allowed amount. If it comes to a carrier's attention that a physician/supplier has received an excessive

amount, inform him/her to refund such amount to the appropriate party. Where it is not clear as to who is entitled to receive the refund under the terms of the private insurance, any excess amount paid by the enrollee may be returned to the enrollee.

A nonparticipating physician/supplier who accepts assignment for some Medicare covered services is not ordinarily precluded from billing the patient for other Medicare covered services for which the nonparticipating physician/supplier does not accept assignment, and is also not precluded from billing the patient for services that are not covered by Medicare. However, a physician/supplier may not attempt to circumvent the Medicare allowed amount limitation by "fragmenting" his/her bills. Bills are "fragmented" when a physician/supplier accepts assignment for some services, and claims payment from the enrollee for other services performed at the same place and on the same occasion. When a carrier becomes aware that a physician/supplier is fragmenting his/her bills, it must inform him/her that this practice is unacceptable and that he/she must either accept assignment for, or bill the enrollee for, all services performed at the same place and on the same occasion.

EXCEPTION: In mandatory assignment situations, i.e., where a physician/supplier must accept assignment for certain services as a condition for any payment or for full payment to be made (e.g., clinical diagnostic laboratory tests, physician assistants), he/she may accept assignment for those services without accepting assignment for other services furnished by him/her for the same enrollee at the same place and on the same occasion.

30.3.3 - Physician's Right to Collect From Enrollee on Assigned Claim Submitted to Carriers

(Rev. 12511; Issued:02-15-24; Effective: 01-01-24; Implementation: 03-18-24)

A. Before the Claim is Submitted

The provider (including physicians and suppliers) who is accepting assignment should not attempt to collect more than 20 percent of the charge from the enrollee when the deductible has been met. He or she should, if the occasion arises, be advised not to do so. Any greater amount collected will:

1. Reduce the amount payable to him/her on the assigned claim,

2. Cause the enrollee unnecessary hardship in raising the excess amount, and

3. Require extra work for the carrier in paying this excess to the enrollee instead of the physician.

However, a provider (including physicians and suppliers) may accept assignment after having collected a part of his/her bill. The fact that the enrollee has paid more than any deductible and coinsurance due does not invalidate the assignment.

B. Showing the Amount Collected on the Claims Form

In submitting an assigned claim, the provider (including physicians and suppliers) must show on Form CMS-1500 any amount he/she has collected from the enrollee for these services. This information is essential for correct payment of the benefits due; failure to show the amount paid is likely to result in excessive benefit payment to the provider (including physicians and suppliers) (i.e., a benefit payment which, when added to the amount already paid by the enrollee, will exceed the Medicare allowed amount).

EXAMPLE: The physician accepted assignment of a bill of $300 for covered services and collected $60 from the enrollee, but failed to show on the claim form that he/she had collected anything. The carrier determined the Medicare allowed amount to be $250, and since the deductible had previously been met, made payment of $200 to the physician. Since the physician would have received $190 in benefit payments and the enrollee $10 if the amount collected had been shown on the claim form, the physician has been overpaid $10. When this overpayment comes to light, e.g., by a complaint from the enrollee, the carrier will take necessary corrective action, e.g., advise the physician to refund the $10 to the enrollee and if he/she fails to do so, pay the enrollee the $10 and recover the overpayment from the physician.

C. Physician Should Not Bill Enrollee After the Claim is Submitted

After the provider (including physicians and suppliers) has accepted assignment he/she should not bill the enrollee or try to collect from him/her any additional part of the bill until he/she receives the carrier's Medicare Summary Notice (MSN). Where the provider (including physicians and suppliers) collects any substantial part of his/her bill from the enrollee **after** submitting his/her claim, such collection is likely to be an overcollection, and a violation of the assignment agreement. Furthermore, the enrollee who receives a bill from the provider (including physicians and suppliers) may submit such bill to the carrier with his/her own claim for benefits, causing confusion, possible duplicate payment, or payment of benefits to the enrollee rather than the provider (including physicians and suppliers).

EXAMPLE: The physician accepted assignment of a bill of $300 for covered services, and collected $60 from the enrollee after the Form CMS-1500 had been filed with the carrier, but before receiving notice of the Medicare allowed amount. The carrier determined that the Medicare allowed amount was $250, and since the Form CMS-1500 did not show any payment made by the enrollee, paid the physician $200 (80 percent of the $250 Medicare allowed amount). The result is that the physician has overcollected from the enrollee by $10.

When this overcollection came to light through a complaint from the enrollee, the carrier notified the physician that the $10 must be refunded to the enrollee. Unlike the excess payment made because the physician fails to show the amount collected on the claims form (see the example in B above), this $10 does not constitute a program overpayment;

the carrier should not apply recovery procedures applicable to overpayments, and should not pay the $10 to the patient unless the physician first "refunds" it to the carrier (in lieu of refunding it directly to the patient).

If the physician, **after submitting his/her claim**, collects an additional amount on his/her bill, and the carrier learns of such collection before making SMI payment, the carrier should adjust its payments to the physician and enrollee accordingly. However, even if the physician collected the entire bill, requiring that the full SMI benefit be paid to the enrollee, the Medicare allowed amount limitations of the assignment still apply.

D. Durable Medical Equipment Supplier Bills for Coinsurance at the Time Claim Submitted

Notwithstanding the guideline in C above, a supplier of durable medical equipment may bill the beneficiary for 20 percent of the Medicare allowed amount at the same time it submits an assigned claim to the carrier for the items and services furnished, with the exception of insulin that is administered through a covered item of DME. For such insulin see Pub. 100-04 Chapter 20, – Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), Section 140.1.1 for further instruction.

For all other items, the supplier must undertake:

1. To bill the beneficiary at the time it submits the claim only for 20 percent of the Medicare allowed amount; and

2. To inform the beneficiary prominently on its invoice that:

   a. It has submitted a claim to the carrier for the items and services and he/she should not him/her self submit such a claim; and

   b. The bill is for 20 percent of the Medicare allowable charge and is not covered by Medicare; and

3. To establish and maintain adequate procedures for refund of any over collections from the beneficiary that might result from the carrier approving a different Medicare allowed amount than that submitted.

30.3.4 - Effect of Assignment Upon Rental or Purchase of Durable Medical Equipment on Claims Submitted to Carriers

(Rev. 1, 10-01-03)
B3-3045.3

A. Equipment More Expensive Than Standard Item

An item of durable medical equipment may have certain convenience or luxury features that make it more expensive than a standard item, i.e., one which will adequately meet the medical needs of the patient. The charge for the more expensive item cannot exceed the fee schedule amount for the item adequate for the patient's medical needs. Only if a more expensive item or model with special features is medically necessary for the beneficiary will the Medicare allowed amount be based on the more expensive model. If the patient purchases or rents an item of durable medical equipment having more expensive features than his/her condition requires, the supplier accepting assignment on such an item cannot charge or collect any amount in excess of the Medicare allowed amount for the appliance adequate for the patient's needs. Acceptance of assignment binds the supplier to accept the Medicare allowed amount determined by the carrier, as the full charge for the item. A supplier who wishes to charge and collect the full price for equipment more expensive than medically required by the patient need not accept assignment.

Refer to chapter 30, for advance beneficiary notice (ABN) provisions.

EXAMPLE: An enrollee who needs a wheelchair is sold a motorized chair although a manually operated chair would meet his/her medical needs. The Medicare allowed amount in this case is the Medicare allowed amount for a manually operated chair. Therefore, if the supplier accepts assignment, he/she cannot collect from the enrollee any amount in excess of the difference between the amounts of the SMI benefit paid to the supplier and the Medicare allowed amount for the manually-operated chair.

B. Equipment No Longer Medically Necessary

In assignment cases, the beneficiary is responsible for paying the supplier the unpaid balance of the Medicare allowed amount when payments stop because his/her condition has changed and the equipment is no longer medically necessary. Similarly, when payments stop because the beneficiary dies, his/her estate is responsible to the supplier for such unpaid balance.

NOTE: Carriers should not get involved in issues relating to ownership or title to property.

30.3.5 - Effect of Assignment Upon Purchase of Cataract Glasses From Participating Physician or Supplier on Claims Submitted to Carriers

(Rev. 4201, Issued: 01-18-19, Effective: 02-19-19, Implementation: 02-19-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

A pair of cataract glasses is comprised of two distinct products: a professional product (the prescribed lenses) and a retail commercial product (the frames). The frames serve not only as a holder of lenses but also as an article of personal apparel. As such, they are usually selected on the basis of personal taste and style. Although Medicare will pay only for standard frames, most patients want deluxe frames. Participating physicians and suppliers cannot profitably furnish such deluxe frames unless they can make an extra (noncovered) charge for the frames even though they accept assignment.

Therefore, a participating physician or supplier (whether an ophthalmologist, optometrist, or optician) who accepts assignment on cataract glasses with deluxe frames may charge the Medicare patient the difference between his/her usual charge to private pay patients for glasses with standard frames and his/her usual charge to such patients for glasses with deluxe frames, in addition to the applicable deductible and coinsurance on glasses with standard frames, if all of the following requirements are met:

A. The participating physician or supplier has standard frames available, offers them for sale to the patient, and issues and ABN to the patient that explains the price and other differences between standard and deluxe frames. Refer to Chapter 30.

B. The participating physician or supplier obtains from the patient (or his/her representative) and keeps on file the following signed and dated statement:

> _____
> Name of Patient Medicare beneficiary identifier
> Having been informed that an extra charge is being made by the physician or supplier for deluxe frames, that this extra charge is not covered by Medicare, and that standard frames are available for purchase from the physician or supplier at no extra charge, I have chosen to purchase deluxe frames.
>
> _____
> Signature Date

C. The participating physician or supplier itemizes on his/her claim his/her actual charge for the lenses, his/her actual charge for the standard frames, and his/her actual extra charge for the deluxe frames (charge differential).

Once the assigned claim for deluxe frames has been processed, the carrier will follow the ABN instructions as described in §60.

30.3.6 - Mandatory Assignment Requirement for Physician Office Laboratories on Claims Submitted to Carriers

(Rev. 1, 10-01-03)
B3-3045.5

A. General

No payment may be made for clinical diagnostic laboratory tests furnished by a physician or medical group unless the physician or medical group accepts assignment or claims payment under the indirect payment procedure. Carrier direct payment to a physician or group after the death of the beneficiary is considered assigned payment. Assignment may be accepted for the entire claim. See subsections B and C if a physician wishes to accept assignment only for laboratory services.

B. Submission of Non-EMC Claims

A nonparticipating physician or medical group who furnishes clinical diagnostic laboratory tests and other services to a beneficiary and accepts assignment only for the laboratory tests may either submit a separate (assigned) claim for them or a single claim that includes both the assigned tests and the other unassigned services. In the latter event, the claim must be annotated as unassigned in block 26 of the Form CMS-1500 and a special request for payment for the assigned tests written in block 25, as follows:

> "I accept assignment for the clinical laboratory tests."

C. Submission of EMC Claims

A nonparticipating EMC physician or medical group who furnishes clinical diagnostic laboratory tests and other services and accepts assignment only for the laboratory tests may either submit a separate (assigned) data set for the tests or a single data set that includes both the assigned tests and the unassigned other services. In the latter event, the data set must include the unassigned indicator. The physician or group must have filed a blanket statement agreeing to accept assignment on all clinical diagnostic laboratory tests, not withstanding the inclusion of the unassigned indicator on electronic data sets.

D. Processing Claims

Carriers process as assigned all claims for clinical diagnostic laboratory tests as described above, including those submitted by a participating or non-participating physician or group either marked as unassigned or with no assignment option specified. Where, however, evidence clearly shows that the beneficiary or provider refuses to assign the claim, carriers should deny it. They split a claim containing assigned laboratory tests and other unassigned services.

E. Public Information

Carriers must inform all physicians and medical groups of this policy annually.

30.3.7 - Billing for Diagnostic Tests (Other Than Clinical Diagnostic Laboratory Tests) Subject to the Anti-Markup Payment Limitation - Claims Submitted to A/B/MACs

(Rev. 10236, Issued: 07-31-2020, Effective: 08-31-2020, Implementation: 08-31-2020)

A. General

A physician or other supplier may bill and receive payment for the technical component (TC) or professional component (PC) of a diagnostic test (other than clinical diagnostic laboratory test) that is performed by a physician or other supplier with whom the billing physician or other supplier does not share a practice. Reimbursement for that service is subject to the anti-markup payment limitation. If a physician or other supplier's bill or a request for payment includes a charge for a diagnostic test (other than a clinical diagnostic laboratory test) which the physician or other supplier did not personally perform or supervise, then payment for the test may not exceed the lesser of:

- The performing physician's net charge to the billing physician or other supplier (net any discounts);
- The billing physician's actual charge; or
- The fee schedule amount that would be allowed for the test if the performing physician or other supplier billed directly.

(See §30.2.9 of this chapter for additional information.)

For payment to be made, the physician who acquires the TC or PC of a diagnostic test from an outside source must identify the performing physician or other supplier on the claim. (The billing physician or other supplier should maintain a record of the performing physician or other supplier's NPI in the clinical record for auditing purposes.)

The billing physician or other supplier must also indicate on the claim that the test is subject to the anti-markup payment limitation.

See the guidelines at the official Washington Publishing Company website for how to show this on electronic claims.

If using the CMS-1500 paper claim form:

- In item 20 check "yes" to indicate the test is subject to the anti-markup payment limitation and enter the amount the performing physician or other supplier charged.
- In item 32 enter the name, address, and NPI of the performing physician or supplier. If the performing physician provides the service outside the A/B MAC (B) jurisdiction where the billing physician is located, the billing physician must submit its own NPI with the name, address, and ZIP code of the performing physician or other supplier.

No payment may be made to the physician without this information unless the statement "No anti-markup tests are included" is annotated on the claim.

NOTE: If the billing physician performs only the TC or the PC and wants to bill for both components of the diagnostic test, the TC and PC must be reported as separate line items if billing electronically or on separate claims if billing on paper (CMS-1500). Global billing is not allowed unless the billing physician or other supplier performs both components.

Effective for claims submitted with a receipt date on and after October 1, 2015, the billing physician or supplier must report the name, address, and NPI of the performing physician or supplier in Item 32a of the CMS-1500 claim form (or its electronic equivalent) on anti-markup claims, even if the performing physician or supplier is enrolled in a different A/B MAC (B) jurisdiction. (See §10.1.1.2 for more information regarding claims filing jurisdiction.)

B. Unassigned Claims with Required Documentation

A physician or other supplier may not bill an individual an amount in excess of Medicare's payment, except for any deductible and coinsurance, for the TC or PC of a diagnostic test that is subject to the anti-markup payment limitation. A/B MACs (B) must notify physicians and other suppliers that they must indicate when a diagnostic test was acquired, identify the performing physician or other supplier, and show the amount the performing physician or other supplier charged. The notification must inform physicians and other suppliers that they are prohibited by §1842(n)(3) of the Act from billing or collecting an amount in excess of Medicare's payment, except for the deductible and coinsurance. Excess amounts collected from the beneficiary must be repaid.

C. Unassigned Claims without Required Documentation

A physician may not bill a beneficiary:

- If the bill does not indicate who performed the test; and

- If the bill indicates that a separate physician or other supplier performed the test, it does not identify the performing physician or other supplier or does not include the amount the performing physician or other supplier charged.

The A/B MACs (B) notify the physician when a non-assigned claim for the TC or PC of a diagnostic test subject to the anti-markup payment limitation is received from either the physician or a beneficiary except when the physician submits an assigned claim and the beneficiary submits an unassigned duplicate claim. They use the following sample letter.

Dear Doctor:

We have received an unassigned claim for diagnostic tests furnished to the patient (Beneficiary Name), on (Date of Service). You are prohibited by §1842(n)(3) of the Social Security Act from billing or collecting any amount unless you indicate that "No anti-markup tests are included" or, if the diagnostic test was acquired, you indicate who performed the test and what the physician or other supplier charged you. Some or all of the required information is missing from your patient's claim. If you have collected any amount from your patient, it must be refunded. This claim may be resubmitted if the required information is included.

D. Beneficiary Information Regarding Unassigned Claims

The A/B MACs (B) must notify the beneficiary that the physician is prohibited from:

- Billing the beneficiary when the necessary documentation is not supplied; and

- Billing or collecting an amount in excess of Medicare's payment, except for the deductible and coinsurance, when the required documentation is submitted.

(See chapter 21 of this manual, for MSN messages.)

30.3.8 - Mandatory Assignment and Other Requirements for Home Dialysis Supplies and Equipment Paid Under Method II on Claims Submitted to Carriers

(Rev. 2487, Issued: 06-08-12, Effective: 01-01-11, Implementation: 06-19-12)

B3-3045.7

For services furnished prior to January 1, 2011, the DME MACs pay only on an assignment basis for home dialysis supplies and equipment furnished to a beneficiary who had selected Method II.

Effective for dates of service on and after January 1, 2011, Section 153b of the Medicare Improvements for Patients and Providers Act (MIPPA) eliminated Method II home dialysis claims. All home dialysis claims must be billed by an ESRD facility and paid to the ESRD facility under the ESRD PPS.

Refer to chapter 8 and chapter 20 for more information.

30.3.9 - Filing Claims to a Carrier for Nonassigned Services

(Rev. 702, Issued: 10-07-05; Effective/Implementation Dates: N/A)

A General

Payment for Part B services furnished by a physician (or supplier) is made:

- To the beneficiary on the basis of an itemized bill (nonassigned claims); or

- To the physician (or supplier) who provided covered services on the basis of an assignment of benefit payments where the approved charge is the full charge for the services.

NOTE: For services furnished on or after September 1, 1990, physicians and suppliers must complete and submit both assigned and nonassigned Part B claims for beneficiaries.

B Conflicting Claims

Carriers must establish controls to detect and prevent payment for assigned and unassigned claims received for the same service (as well as duplicate assigned or duplicate unassigned claims.

If an appropriate assigned claim is received after an unassigned claim has been paid, carriers do not pay the subsequent claims. Where an enrollee's claim based on an unpaid bill is received and benefits are payable, carriers make payment to him/her unless there is some definite basis for believing that payment has been assigned, e.g., the physician or supplier is a "participating" provider or the bill from a nonparticipating physician or supplier shows that assignment may have been made.

Carriers are instructed to inform physicians that, if they wish to be sure of receiving Part B benefits, they should accept assignment at the time services are furnished and that their submission of claims to the carrier should not be unduly delayed.

30.3.10 - Carrier Submitted Bills by Beneficiary
(Rev. 1, 10-01-03)
B3-3040.1

Carriers do not make payment for non-receipted itemized bills without a Form CMS-1490S claim form signed by either the patient or his/her representative.

Note that CMS does not accept beneficiary submitted claims for items subject to mandatory assignment.

They also do not accept them for blood glucose test strips effective April 1, 2002.

30.3.11 - Carrier Receipted Bill - Definition
(Rev. 1, 10-01-03)
B3-3040.2

A receipted bill is a written acknowledgment by a person or organization furnishing specified covered services, which states that payment has been made for all services on the bill.

Where a receipted bill is submitted, benefits for the services shown on the bill should not be paid to the physician (or his/her supplier) since there can be no assignment. (See §20)

The bill itself bearing the words "received payment," "paid in full," "paid," or a phrase with the same meaning, is the best evidence of payment if it is signed or initialed by the physician (or his/her employee, etc.) or by the person or organization furnishing supplies or services. There will, however, be other evidence of payment that will be acceptable, such as machine-produced bills that clearly show the amount paid for each service. A rubber-stamp imprint on the bill which includes the name of the physician or other supplier is acceptable, absent a reason to question it. It is also reasonable to accept, as evidence of payment, a cancelled check that is related in time and amount to a doctor's, or other Part B supplier's bill.

A bill paid by promissory note is treated as a "receipted bill" unless the bill shows on its face that the note is **not** given and accepted unconditionally as payment of the bill. For example, a bill marked "paid by promissory note" or "$25 paid in cash, balance paid by promissory note" is treated as a receipted bill. On the other hand, a bill marked "paid subject to payment on promissory note," or which otherwise clearly indicates that the promissory note was not unconditionally accepted in payment of it, is not a receipted bill.

30.3.12 - Carrier Annual Participation Program

(Rev. 702, Issued: 10-07-05; Effective/Implementation Dates: N/A)

For providers (including physicians and suppliers) who have enrolled in Medicare, to sign a participation agreement (Form CMS-460) is to agree to accept assignment for all covered services that are provided to Medicare patients. The benefits of signing a participation agreement include:

- No 5 percent reduction in the Medicare approved amount.

- Beneficiaries with Medigap coverage (private supplemental insurance) may assign the payment on the supplemental claim to the provider or supplier. Under the current mandatory Medigap (claim-based) crossover process, beneficiaries must assign payment on their claims to a participating provider or supplier as a condition for their claims to be forwarded to their Medigap insurer for payment of all coinsurance and deductible amounts due under the Medigap policy. The Medigap insurer, in turn, must pay the participating provider or supplier directly, thereby relieving the need of having to file a second claim. (Refer to the Medicare Claims Processing Manual, Chapter 28, Section 70.6, for more information regarding the eligibility-file based crossover process.)

- Listing in the Medicare Participation Physicians/Suppliers Directory (MEDPARD) that is posted on the carrier Web site.

- Participants receive direct and timely reimbursement from Medicare.

Refer to §30.3.1 for processing instructions for claims for practitioner services inadvertently submitted as unassigned.

A Eligibility

All practitioners and suppliers eligible to receive payments under Part B of Medicare may choose to enter into a participation agreement. This includes practitioners whose services are subject to mandatory assignment. The reason why it could still be appropriate for such practitioners to enter into a participation agreement is because the mandatory assignment provisions apply only to the particular practitioner service benefit (e.g., nurse practitioner services). Thus, for example, if a nurse practitioner is eligible to bill for, and is indeed billing under, Part B for something other than a nurse practitioner service (e.g., an EKG tracing), the mandatory assignment provision of the law does not apply to that other service. However, if the nurse practitioner has entered into a participation agreement, that agreement requires that the nurse practitioner accept assignment for any service for which he or she submits a Medicare Part B claim.

B Participation Enrollment Period

Carriers conduct an enrollment period on an annual basis in order to provide eligible practitioners and suppliers with the opportunity to enroll in or terminate enrollment in the participation program. They are given specific instructions each year regarding the dates during which the enrollment period is in effect.

C Circumstances in Which A Participating Physician or Supplier is Not Required to Accept Assignment for Covered Services

A participating physician or supplier is not required to accept assignment for covered services when an entity (other than the beneficiary), which is eligible to request direct payment from the Medicare program for the services, pays the physician or supplier and the physician or supplier accepts that payment as full payment.

For example, a private supplementary health benefits plan may pay the physician or supplier an amount, which the physician or supplier accepts as payment in full and then collect the Part B payment directly from the Medicare program. This procedure, called indirect payment or payment to organizations, permits a physician or supplier to submit a single claim for the Medicare and private plan benefits to the private health benefits plan. The physician or supplier may accept plan payment in excess of the Medicare approved charge.

The availability of this procedure depends on the extent to which health benefit plans are eligible and choose to use it. The indirect payment procedure is also available to nonparticipating physicians or suppliers.

D Entities Eligible to Enter Into Agreement to Be Participating Physicians or Suppliers

Any person or organization that is authorized to accept assignment of Medicare benefits for covered services may enter into a participating physician agreement. This includes (but is not limited to):

- Practitioners such as physicians, podiatrists, dentists, optometrists, and chiropractors;

- Hospitals, medical groups, and other entities which are authorized to bill and to receive payment for physician services;

- Organizations such as group practice prepayment plans, prepaid health plans, HMOs, and competitive medical plans which submit claims to Medicare carriers; and

- Suppliers such as independent physical therapists, medical equipment supply companies, independent laboratories, ambulance services, and portable X-ray suppliers.

E Applicable Rules When Physicians Work for a Hospital or Medical Group

The following rules apply when physicians work for (or are members of) a hospital, medical group, or other entity:

- Except in the case of university medical centers, if a hospital, medical group, or other entity bills and receives payment for physician services in the name of the entity (rather than have the individual physicians bill and receive payment in their own names), one participation agreement by the entity binds all physicians with respect to any services furnished for the entity. The individual physicians do not enter into participation agreements.

  > **NOTE:** In university medical centers, when individual departments bill under the name and provider identification number of the department, decisions for or against participation can be made on a departmental basis.

- If a physician who is associated with a particular entity has an individual practice outside the scope of the practice for which the entity bills and receives payment, he or she may choose whether to participate with respect to his/her outside practice without regard to the participation status of the entity.

- If individual physicians who work for an entity bill and receive payment in their own names for the services furnished for the entity, they make individual decisions as to whether to participate. These decisions apply both to the physicians' services for the entity and to any outside practice.

F Services Subject to Agreement

The participation agreement applies to items and services for which payment is made on a fee-for-service basis by Medicare Part B carriers. A participating agreement applies to all items and services in all localities and under all names and identification numbers under which the participant does business.

The participant lists all names and identification numbers under which the participant submits claims to the carrier. This includes all names and numbers of the legal entity entering into the agreement, whether that entity is a sole proprietorship, partnership, or corporation.

If the participant opens offices in another carrier jurisdiction during the term of the agreement, he or she must file a photocopy of the agreement with that carrier.

G Acknowledgment of Receipt

Carriers acknowledge receipt of an agreement by sending the physician or supplier a photocopy of the agreement, which has been annotated with the effective date.

H Where to File Agreement

An agreement is valid if it is filed with any Medicare carrier in a timely manner.

A new participant must file an original agreement with the carrier in their region and a photocopy of the agreement by a date that CMS specifies on an annual basis with any other carriers which have assigned the participant a physician identification number and to which the participant submits claims. When submitting a photocopy of the agreement to a carrier, the new participant must identify in the letter transmitting the photocopy all names and identification numbers under which the participant submits claims to that carrier and indicate the name of the carrier to which the original agreement was mailed or delivered and the date it was mailed or delivered.

If the new participant enters into a valid agreement but does not also timely file a photocopy of the agreement with another carrier with which the participant does business, it may be too late for the participant to be listed in that carrier's directory of participating physicians. Nevertheless, the agreement is still binding, and it is important for the physician or supplier to submit a photocopy of the agreement to that carrier, even if late, because of advantages of the agreement, which are still available with late filing.

It is not necessary for the new participant to file a photocopy of the agreement with Palmetto GBA, the carrier for Railroad Retirement Board beneficiaries. The new participant's carrier will furnish Palmetto GBA with participating physician/suppler data (see Section 30.3.12.1.J. of this chapter).

Note that for DMEPOS suppliers, the NSC handles the participation agreements.

I Duration of Agreement

An agreement entered into, or continuing in effect, for a given year remains in effect through that year and may not be revoked during that period.

The agreement is renewed automatically for each 12-month period thereafter unless, during the enrollment period provided near the end of the 12-month period, the participant gives proper written notice of a wish to terminate the agreement at the end of its current term. Proper written notice means written notice to all carriers with whom the participant has filed the agreement or a copy of the agreement.

The CMS may terminate the agreement if it finds, after notice and opportunity for hearing, that the participant has substantially failed to comply with the agreement. There are also civil and criminal penalties, identical to those for assignment violations, which may be imposed for violation of the agreement.

Note that for DMEPOS suppliers, the NSC handles the participation agreements.

J When New Physician or Supplier in Area May Enter Into Agreement

A physician/supplier who has enrolled in the Medicare program and wishes to become a participating physician/supplier must file an agreement with a Medicare carrier within 90 days after either of the following events:

- The participant is newly licensed to practice medicine or another health care profession; or

- The participant first opens offices for professional practice or other health care business in a particular carrier service area or locality (regardless of whether the participant previously had or retains offices elsewhere).

If a physician has an arrangement with a hospital, medical group, or other entity under which the entity bills in its name for his/her services, changes that arrangement and then begins to bill in his/her own name, he/she is considered to be first opening offices, even though he/she practices in the same location.

The participating enrollment package is included with the CMS-855 form for new enrollees. Carriers must furnish a special participating agreement form for new physicians or suppliers upon request or at the time you assign the new physician or supplier an identification number.

When the agreement is filed on one of the above bases, it is effective on the date of filing, i.e., the date the participant mails (postmark date) the agreement to the carrier or delivers it to the carrier. The initial period of the agreement may be less than 12 months. Otherwise, the terms of the agreement are the same as those of an agreement entered into

by other physicians or suppliers. The agreement applies to all services in all localities. The physician or supplier must submit the original agreement to the carrier in their region and photocopies to all carriers with whom he or she deals.

If a physician or supplier first enters into an agreement after publication of your directory, his or her name is not included in the directory until subsequent publication. This may not occur until the next annual publication date. Carriers must make the names of those physicians or suppliers entering into agreements after the initial deadline available on the toll free telephone lines as each physician or supplier enters into an agreement.

Note that for DMEPOS suppliers, the NSC handles the participation agreements.

30.3.12.1 - Annual Open Participation Enrollment Process

(Rev. 12448; Issued:01-11-24; Effective: 01-01-24; Implementation: 02-12-24)

A. Participation Period

The annual physician and supplier participation period begins January 1 of each year, and runs through December 31. The annual participation enrollment is scheduled to begin on November 15 of each year. Carriers will receive the participation enrollment material under separate cover.

NOTE: The dates listed for release of the participation enrollment/fee disclosure material are subject to publication of the Final Rule.

B. Participation Enrollment and Fee Disclosure Process Background

Every year, contractors conduct an open participation enrollment period in order to provide eligible physicians, practitioners and suppliers with an opportunity to make their calendar year Medicare participation decision. The open enrollment period runs from November 15 to December 31.

Until 2004, the Medicare contractors mailed each provider a hardcopy package which included enrollment materials, a paper copy of the Medicare Physician Fee Schedule (MPFS), an Announcement document, the Medicare Participating Physician or Supplier Agreement (Form CMS-460), and a variety of provider education material about the Medicare program. Beginning with the 2005 mailing, CMS directed Medicare contractors to begin using a CD for the participation mailing because it was less expensive than mailing the hardcopy materials.

Beginning with the 2006 mailing, contractors placed the new Medicare fees on their Web sites and did not include the fees on the CDs due to frequent last minute changes to the MPFS. Removing the Medicare fees from the CD provided greater flexibility for updates late in the year due to legislative changes or CMS payment policy decisions.

Since the fee schedules are no longer included on the CD, and the educational materials, as well as the Form CMS-460, are also posted on contractors' Web sites, the value of the CD to the provider community has diminished. Beginning 2011, CMS is directing contactors to produce a postcard mailing, instead of a CD, for eligible physicians, practitioners and suppliers.

B1. Postcard Mailing

No later than October 31st of each year, beginning in 2011, contactors should produce a postcard for the annual open participation enrollment period. Providers that do not have access to the internet must be educated to contact their local contractors to request a hard copy disclosure package. The annual post card will remind the Medicare health professional community to view their local contractor's Web site regarding information for the upcoming open participation enrollment period. The postcard also will remind health professionals that the new MPFS update is posted on their local contractor's Web site.

Carriers/MACs must annotate the postcard with the following message:

Medicare Participating Provider Program

<Insert Upcoming Year> Participation Enrollment and Fee Disclosure Information

This is a reminder that the <insert upcoming year> Annual Participation Open Enrollment Period is approaching. The open enrollment period runs mid-November through December 31. Refer to your local Medicare contractor's Web site at <insert the "Medicare Participating Provider" Web site> to obtain more specific information about the Annual Participation Open Enrollment Period. Medicare Physician Fee Schedule for services rendered during <insert upcoming year> are also posted on your local Medicare contractor's Web site.

If you do not have internet access, contact your local Medicare Contractor at <insert contractor's toll free number>to request a hardcopy Participation Enrollment and Information Package which includes the new Medicare fees.

The carrier/MAC mails the participation enrollment postcard and/or hardcopy fee disclosure packages via first class or equivalent delivery service, and schedules the release of material so that providers receive it no later than the date provided in the annual participation enrollment instruction.

B2. Web site

Each October, carriers/MACs should post a notice on their Web site regarding the upcoming participation enrollment period reminding physicians and practitioners that the upcoming MPFS will be published on the carriers/MACs Web site after the physician fee schedule regulation is put on display.

Carriers/MACs must assure providers have access to specific information about the Annual Participation Open Enrollment Period via a single page on their Web site. Carriers/MACs must include the following information and/or links to following on this page: the Annual Announcement, the Medicare Participating Agreement (Form CMS-460), the Medicare Physician Fee Schedule Fee Disclosure, detailed instructions for submitting the participation enrollment forms or disenrollment requests, and any supplemental educational information you see fit. Carriers/MACs need to include information regarding whom the provider can contact if assistance is required. Also, CMS may instruct all carriers/MACs to include a specific item(s) as part of the additional supplemental material on their Web site. (**EXAMPLE:** A note from the administrator, a special file, etc.)

Carriers/MACs must place the new fees and the anesthesia conversion factor(s) on their Web site after the final rule is placed on display. The CMS transmits the Medicare Physician Fee Schedule Database electronically to carriers/MACs each year around late-October. CMS notifies the carrier/MACs that the annual MPFS files, including anesthesia, are available in an email notification. The email notification also contains the file names.

The CMS will furnish carriers/MACs, via a separate instruction, with the participation materials used for the annual participation open enrollment period, including the Announcement, which shall be displayed on contractor's Web site. Carriers/MACs must mail a postcard reminding providers to look at the contractors' Web site for information regarding the annual open participation enrollment period.

B3. Physicians/Practitioners/Suppliers

The postcards are sent to the following physicians and suppliers in accordance with the following guidelines no later than November 15 of each year, subject to the publication of the Final Rule:

- All physician specialties included in the 01-99 specialty range;
- Independently practicing occupational and physical therapists (specialty 65 and 67);
- Suppliers of diagnostic tests;
- Suppliers of radiology services (including portable x-ray suppliers-specialty 63);
- Multi-specialty clinics (specialty 70);
- Independent laboratories (specialty 69-since they can typically bill for anatomic pathology services paid under the Physician Fee Schedule);
- Mammography Screening Centers (specialty 45);

- Independent Diagnostic Testing Facilities (specialty 47);

- Audiologists (specialty 64); and

- Independently Billing Psychologists (specialty 62).

NOTE: Chiropractors and Mammography Screening Centers do not need to view the entire locality fee schedule report. Therefore, carriers/MACs may add separate headings on their Web site listing the fee data for the procedure codes that they may receive payment.

Carriers/MACs send an annual participation announcement and a blank participation agreement to the following non-participating suppliers:

- Ambulatory Surgical Centers (ASCs) (specialty 49); (Although ASCs must accept assignment for ASC facility services, they may also provide and bill for non-ASC facility services, which do not have to be billed as assigned and which are therefore subject to a participation election); and,

- Supplier specialties other than 51-58; (Supplier specialties 51-58 will receive a separate enrollment package from the National Supplier Clearinghouse).

Carriers/MACs may create hard copy fee disclosure reports and send them to specialty 49, and supplier specialties other than 51-58, if cost effective to do so (e.g., carriers determine that fee disclosure to suppliers will reduce the number of more costly supplier inquiries for fee data). To minimize report programming costs, carriers may use the same format as the physician fee disclosure report. If they use the physician fee disclosure report format for supplier fee disclosure, carriers include a disclaimer advising the supplier that the non-participating fee schedule amounts and limiting charges do not apply to services or supplies unless they are paid for under the Physician Fee Schedule. If carriers elect not to routinely disclose supplier fees with their participation enrollment packages, they must furnish suppliers with their applicable fee schedules or reasonable charge screens upon request.

Instructions for completing the enrollment process for non-durable medical equipment, prosthetic, orthotic, and supplies (DMEPOS) suppliers will be issued under separate cover. Those instructions will address the responsibilities of durable medical equipment regional carriers (DMERCs) and the National Supplier Clearinghouse.

C. Minimum Requirements for Disclosure Reports for Posting on the Web and Hard Copies

Carriers must place the following information on the web sites and also in their hard copy disclosure reports.

- Carriers must use valid CPT and HCPCS codes for creating disclosure reports for physician fee schedule services when posting this information on the web. CMS provides carriers with complete locality data for all procedure codes with a status indicator of A, T, and R (for which CMS has established the RVUs) on the Medicare Physician Fee Schedule Database (MPFSDB). Included on the MPFSDB are payments for the technical portion of certain diagnostic imaging services (including the technical portion of global imaging services) that are capped at the Outpatient Prospective Payment System (OPPS) amount. Limiting charges are included on the annual disclosure reports of providers who may be subject to the nonparticipant fee schedule amount, if they elect not to participate for a calendar year. The limiting charge equals 115 percent of the nonparticipant fee schedule amount.

For the facility setting differential, the limiting charge is 115 percent of the nonparticipant fee for the differential amount.

The data for Locality Fee Schedule Reports are:

--Header Information – Locality identification (on each report page);

--Procedure Codes – Carriers must array all codes paid under the Physician Fee Schedule. They include global, professional component and technical component entries where applicable:

--Par Amount (nonfacility);

--Par Amount (facility based);

--Non-par Amount (nonfacility);

--Limiting Charge (nonfacility):

--Non-par Amount (facility based); and

--Limiting Charge (facility based);

--Footer Information – The following must be included on the fee disclosure reports:

1. The legend: "All Current Procedural Terminology (CPT) codes and descriptors are copyrighted (appropriate year) by the American Medical Association" (on each report page).

NOTE: The CMS has signed agreements with the American Medical Association regarding the use of CPT, and with the American Dental Association regarding the use of CDT, on Medicare contractor Web sites, bulletin boards and other

contractor electronic communications. If the carrier uses descriptors, it must use short descriptors. The appropriate CPT copyright year must be inserted each year. For example: the 2006 CPT is copyrighted 2005; the 2007 CPT is copyrighted 2006; in each case, the appropriate year for the copyright is inserted by the contractor.

2. The legend: "These amounts apply when service is performed in a facility setting."

3. The legend: "The payment for the technical component is capped at the OPPS amount."

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

In addition, the carrier includes language in a bulletin that provides an explanation of the facility-based fee concept (e.g., facility-based fees are linked to their own separate RVUs independent of the non facility RVUs).

D. Disclosure to Medical Societies and Other Parties

Carriers send first class or equivalent (e.g. UPS), free of charge, a complete fee schedule for the entire State (or your service area if it is other than the entire State) to State medical societies and State beneficiary associations. Carriers may negotiate with them as to the medium in which the information is to be furnished.

Carriers send local medical societies and beneficiary organizations a free copy of their respective locality fee schedule. If a fee schedule for the entire service area is requested by a local medical society or beneficiary organization, furnish one free copy. If more than one copy of a complete fee schedule for the carrier service area is requested, carriers charge for extra copies in accordance with the Freedom of Information Act (FOIA) rules. If a provider requests a fee schedule for a locality in which he/she has no office, carriers may charge them in accordance with FOIA rules.

E. Practitioners Subject to Mandatory Assignment

Some practitioners who provide services under the Medicare program are required to accept assignment for all Medicare claims for their services. This means that they must accept the Medicare allowed charge amount as payment in full for their practitioner services. The beneficiary's liability is limited to any applicable deductible plus the 20 percent coinsurance. The following practitioners must accept assignment for all Medicare covered services they furnish, and carriers do not send a participation enrollment package to these practitioners:

- Specialty 32 - Anesthesiologist assistants (AAs)

- Specialty 42 - Certified nurse midwives

- Specialty 43 - Certified registered nurse anesthetists (CRNAs)
- Specialty 50 - Nurse practitioners
- Specialty 68 - Clinical Psychologists
- Specialty 71 - Registered dietitians/nutritionists
- Specialty 73 - Mass Immunization Roster Billers
- Specialty 80 - Clinical Social Workers
- Specialty 89 - Clinical nurse specialists
- Specialty 97 - Physician assistants
- Specialty E1 - Marriage and Family Therapists
- Specialty E2 - Mental Health Counselors

NOTE: The provider type Mass Immunization Biller (specialty 73) can bill only for influenza and pneumococcal vaccinations and administrations. These services are not subject to the deductible or the 20 percent coinsurance.

Although these practitioners will not be invited to officially enroll in the Medicare participation program, carriers treat them as participating practitioners for purposes of various benefits available under that program (See Section 30.3.12 in this Chapter).

NOTE: Although these practitioners do not have to sign participation agreements, carriers must include them in the annual MEDPARD as participating. They also include Rural Health Centers.

Carriers may create and send hardcopy fee disclosure reports to these practitioners if cost effective to do so (e.g., the carrier determines that fee disclosure to these practitioners will reduce or minimize the number of more costly inquiries it receives for fee data). To minimize report programming costs, carriers may use the same format as the physician fee disclosure report. If they use the physician fee disclosure report format for practitioner fee disclosure, carriers include a disclaimer advising the practitioner that the non-participating fee schedule amounts and limiting charges do not apply to services they furnish. If carriers elect not to routinely disclose practitioner fees, they furnish applicable fees or reasonable charge screens upon request.

The Medicare Participation Agreement and general instructions are on the CMS Web site at http://www.cms.hhs.gov/cmsforms/downloads/cms460.pdf.

F. Supplier Fee Schedule Data

Refer to Chapter 23 for more information.

Clinical Laboratory Fee Schedule

Carriers must:

- Publish clinical diagnostic lab fees in a regularly scheduled bulletin or newsletter.
- Publish clinical laboratory fees in the following format:
  - Header Information: Name of fee schedule and State or locality (if less than State-wide) on each report page:
  - Procedure Code and Modifiers (Use procedure codes that are valid for appropriate year);
  - Fee Schedule Amount; and
  - Footer Information: The legend "All Current Procedural Terminology (CPT) codes and descriptors are copyrighted (appropriate year) by the American Medical Association." (on each report page).

Information regarding release of this data will be issued under separate cover.

DMEPOS Fee Schedule:

Instructions for furnishing DMEPOS fee schedule data will be issued annually by CMS.

G. Fee Schedule Printing Specifications

Carriers are to produce hardcopy disclosure material for no more than two percent of their total number of providers. Carriers have the discretion to produce either one or two percent hardcopy versions. The hard copy fee schedules are to be mailed to providers who are **unable** to access the carrier Web site (i.e., do not have internet access). For those providers, carriers must print fee schedules on 8-1/2 by 11-inch paper, and use a print size that accommodates up to 15 characters per inch. The CMS prior approval for smaller print must be requested in writing from the RO. Requests are to be accompanied by print samples to assist the RO in assessing report readability.

H. Date of HCPCS Update

The annual HCPCS update occurs on January 1 of each year. The annual HCPCS update file will be released electronically in October of each year.

I. Medicare Participation Physicians/Suppliers Directory (MEDPARD)

Annually, within 30 days following the close of the annual participation enrollment process, carriers produce a directory listing only Medicare participating physicians and suppliers and post it on their Web site. Carriers do not print hardcopy participation directories (i.e., MEDPARDs) without regional office prior authorization and advance approved funding for this purpose. Carriers load MEDPARD equivalent information on their Internet Web site. Carriers notify providers via regularly scheduled newsletter as to the availability of this information and how to access it electronically. Carriers also inform hospitals and other organizations (e.g., Social Security offices, area Administration on Aging offices, and other beneficiary advocacy organizations) how to access MEDPARD information on the carrier Web site.

Carriers that receive MEDPARD inquires from beneficiaries who do not have access to their Web site will ascertain the nature and scope of each request and furnish the desired MEDPARD participation information via telephone or letter.

(a). Contents

Each directory has two parts. Part I shows the correct Specialty, Name, Address and Telephone Number of each participating Physician, Supplier and Group by geographic area. The address in the directory must be the address of the physician's/supplier's place of business and not a Post Office box number. Part II includes only the name and telephone number of all Physicians, Suppliers and Groups contained in Part I listed in alphabetic sequence. Telephone numbers may not be omitted. Edit the listings to assure that everyone listed in Part I is also listed in Part II (multiple addresses may be included if appropriate); physicians are listed only once by name in Part II.

When you have only the group name for participating group practices, you may list the names of physician(s) within the group, but only at the group's request. For groups which so request, list the physicians under the group name in alphabetical sequence. Indicate an individual physician's specialty if it differs from other specialties. Show only the group address and telephone number. (**NOTE:** A group practicing physician who also has solo practices may appear more than once if he is participating in more than on entity.)

Do not list the names of hospital based physicians.

Where a beneficiary would not have personal choice access to a group, (e.g., the group accepts patients by referral only), list only the group name and address. Note that it accepts patients by referral only.

If a physician or supplier has multiple service locations, accommodate this in the directories to the extent possible with the information on the provider file and information obtained during the participation enrollment process.

List all independent RHCs in your area, not necessarily jurisdiction, in the MEDPARD. They are required to accept Medicare payment on claims as payment in full and, therefore, meet the acceptance criteria for a MEDPARD listing even though a participating agreement has not been signed. Do not group independent RHCs with physicians in the directory. List them separately on a full or partial page under the wording shown below. Show the name, address and telephone number of each. Treat the RHC as a group and list only the clinic name and telephone number in Part II of the MEDPARD (the alphabetical listing). Use an indicator so the beneficiary can distinguish between a group and a RHC.

The following wording must appear above the list of independent RHCs:

> "Rural Health Clinics (RHCs) agree to accept payment by the Medicare program as full payment for their services, except for the applicable deductible and coinsurance amounts for which the beneficiary is responsible. The independent RHCs in the area are listed below:"

(b). Organization (Geographic, Physician/Supplier/Group, Alphabetic)

Prepare a separate MEDPARD for each geographic area, e.g., depending upon size, one for each metropolitan area or one for each county or group of counties. Your plan must be submitted to RO for approval prior to production. Divide each MEDPARD into two parts.

Divide Part I first alphabetically by geographical location. Within each location, list each specialty. Under the specialty, alphabetically list Physicians, Suppliers and Groups with their addresses and telephone numbers. Include optometry and podiatry as specialties and not as suppliers. Add lay terminology to all specialty headings, e.g., ophthalmology (eye disease), so that they are easily understood by the beneficiary. Do not list any "miscellaneous" or "unknown" specialties. These should default to "General Practice" or "Other."

Part II is a straight alphabetical listing of all Physicians, Suppliers and Groups in the directory, with their telephone numbers. If a physician's or supplier's name and address are the same and listed more than once in Part I, list that individual only once in Part II.

(c). Paper, Print, Binding

Carriers with regional office prior authorization and advanced funding can prepare the MEDPARD in hardcopy (booklet) form on white offset book paper. Size the directory by the number of participating physicians/suppliers in your area. Do not exceed 8 1/2 by 11 inches. Use print comparable to 10 point type or larger which improves the readability of the directory. Use type set print rather than computer listings. Put all geographical location and specialty headings in bold, uppercase lettering.

Bind the directory in an attractive and distinctive cover which displays the red, white and blue emblem of the Medicare participating physician. This emblem must show association with "U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES Centers for Medicare & Medicaid Services." clearly indicate on the front cover that this is a Medicare directory of participating physicians/suppliers. Date the MEDPARD so that older editions will not be confused with subsequent ones.

The back cover should function as an envelope for the directory. Put your name and return address in the upper left corner. Reserve the upper right corner for 3rd class postage. Use address labels, generated from your records of directory requests, to make the directory a self-mailer.

Carriers with regional office prior authorization and advanced funding for the MEDPARD in booklet form must produce it within 45 days following the close of the annual participation enrollment process.

(d). Interpretive Information

Each directory must have a Table of Contents. Include detailed instructions on the organization of the directory. Place your name and toll-free telephone number at the bottom of the instructions in the front of the directory. Include detailed instructions on "how to use the directory," i.e., to locate a participating physician or supplier in a specific area: first, find the correct county in the table of contents; second, look below the county for the city name and find the city's page number; third, turn to the appropriate page and look for the physician or supplier specialty you need; fourth, look for the names of physicians or suppliers in that specialty. At the top of the instruction page, include the statement: "This directory contains the names, addresses, telephone numbers, and specialties of MEDICARE PARTICIPATING physicians and suppliers. MEDICARE PARTICIPATING physicians and suppliers have agreed to accept assignment on all Medicare claims for covered items and services."

(e). Dissemination of MEDPARD Information

Within your Medicare service area, inform the following groups how to access the MEDPARD on the carrier Web site:

- Beneficiaries who request to view the MEDPARD; and
- Physicians, suppliers, groups, and clinics listed in the directory who request to view the MEDPARD.

Within 30 days after the close of the annual participation enrollment period, carriers inform the following individuals/groups of the availability of their local MEDPARD on the carrier Web site:

- Congressional offices;

- Quality Improvement Organizations;
- Senior citizen groups and other beneficiary advocacy organizations;
- Social Security Offices;
- State area agencies of the Administration on Aging; and
- Hospitals.

If you receive inquiries from a customer who does not have access to your Web site, ascertain the nature and scope of each request and furnish the desired MEDPARD participation information via telephone or letter.

(f). Alternative Method

You may produce the MEDPARD on diskettes or transmit it electronically. Send alternative mediums to those entities or individuals who wish to receive them in forms other than paper.

Carriers add their local MEDPARDs to their Web sites and inform the various organizations who use the directory of its availability. Publicize Web site MEDPARD access information at least annually in your regularly scheduled newsletters.

(g). Reporting Requirements

Carriers with regional office prior authorization and advanced funding for the MEDPARD in hardcopy form must maintain a record of all hardcopy directories that were distributed. Submit an initial printing/distribution/cost report within 90 days after the close of the annual participation enrollment period. Send the report to your RO and copy CO at the following address:

Director, Division of Practitioner Claims Processing
Centers for Medicare & Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

Include the following information in your initial report: (1) the number of MEDPARDs initially printed; (2) the number of MEDPARDs distributed to each category in (e) above within 60 days after the close of the annual participation enrollment period; and (3) the cost per directory distributed (e.g., printing and distribution costs).

Submit a year end report no later than 45 days after the end of the fiscal year. On the year end report, include the actual number of MEDPARDs printed and the number of MEDPARDs distributed to each category during the fiscal year. Include the cost per

directory distributed on your initial report and include an explanation as to the reason for the adjusted year end cost figure.

J. Furnishing Participating Physician/Supplier Data to Railroad Retirement Board (RRB)

(a). Furnishing RRB with participating information for the general enrollment period:

Within 30 days after the annual participation enrollment period has closed, all carriers must furnish their entire physician/supplier file. The file is to be transmitted to RRB at the same time the MEDPARD is being posted on the carrier Web site. Submit the file in the following format:

1. File Specifications

Carriers send the Provider Participation File (PPF) via CD or cartridge to the RRB carrier. Enter the external label for the file as follows:

FROM:
TO:
DATE:
DATA SET NAME: "Provider Participation File" (PPF).

A. Header Type Specifications

	Field	Position	Picture	Remarks/Field Value
1.	Label	1-3	x (3)	"PPF"
2.	Carrier No.	4-8	9 (5)	Carrier number assigned by CMS.
3.	Date File Updated	9-14	x (6)	MMDDYY

B. Detail Record Specifications.--

	Field	Position	Picture	Remarks/Field Value
1.	TIN/EIN	1-9	9 (9)	Tax identification number used to report income (1099).
2.	UPIN	10-15	x (6)	Unique Physician Identification Number. If not available or applicable, fill with spaces.
3.	Locality	16-17	x (2)	Locality or area designation associated with TIN/EIN.
4.	Current Year Par Indicator	18	x (1)	"Y" = Par "N" = Nonpar
5.	Current Year of Practice	19	9 (1)	1 = First year 2 = Second year 3 = Third year 4 = Fourth year

				5 = Established Provider
6.	Carrier PIN	20-29	x(10)	The provider's carrier-assigned provider identification number.
7.	Physician/Supplier Name	30-54	x (25)	Last Name = 14 First Name = 10 Middle Initial = 1 or Corporate Name = 25 The format for provider name is a total of 25 bytes. Individual providers must have a comma between last name, first name, and middle initial (i.e., Smith, John, M). Space one position between multiple words in corporate names (i.e., Jones Medical Supply).
8.	Physician/Supplier Address	55-110	x (56)	Street Address = 30 City = 15 State Code = 2 Zip Code = 9 Space between numerics and words and space between multiple words. Left justify ZIP Codes. The first five ZIP Code spaces must be numeric and the last four spaces can either be numeric or spaces. Separate street address, city and state with commas, e.g., "1234 Security Boulevard, Baltimore,MD,567891234"

Carriers send the physician/supplier file to:

Attn: Manager, Provider Enrollment
Palmetto GBA
Railroad Retirement Board
2743 Perimeter Pkwy
Building 200, Suite 400
Augusta, GA 30909

(b). Furnishing RRB with participating information for other than the general enrollment period:

After furnishing an annual provider file, inform the RRB carrier, on a flow-basis, of all participating doctors, practitioners and suppliers who enroll after the annual general enrollment period. Carriers send the RRB carrier copies of participation election forms received from physicians, practitioners and suppliers who enrolled after the annual enrollment and, therefore, were not included on the provider file transmitted to the RRB carrier. Transmit copies of such participation enrollment forms via cover letter or fax. Include the following information in your cover letter or fax cover sheet:

- Tax Identification (TIN) or Employer Identification Number (EIN);
- UPIN or NPI when required;
- Locality designation associated with the TIN/EIN;
- Current Year of Practice;
- Carrier PIN or NPI when required; and
- Participation Effective Date.

NOTE: If any of the above information is entered/displayed on the participation agreement form being transmitted, you do not need to include that piece of information in your cover letter or you may state "see attached participation agreement" for that particular item of information.

Carriers send photocopy participation agreements by mail to:

Attn: Manager, Provider Enrollment
Palmetto GBA
Railroad Retirement Board
2743 Perimeter Pkwy
Building 200, Suite 400
Augusta, GA 30909

For participation agreements transmitted via fax call (706) 855-3049.

K. Key Implementation Dates

A detailed schedule of key implementation dates will be provided in an annual temporary instruction in advance of receiving the MPFS Database file. The following outlines significant disclosure activities and anticipated implementation dates. A detailed schedule is provided under separate cover by CMS.

Carriers must:

October:

- Download fee schedules
- Download HCPCS

November:

- Release participation materials and disclosure reports;
- Furnish yearly physician fee schedule amounts to CMS for carrier priced codes;

December:

- Furnish DMEPOS fee schedule and physician fee schedules to State Medicaid Agencies;
- Furnish conversion factors and inflation indexed charge data to the carrier State Medicaid Agencies;
- Process participation elections and withdrawals; and,
- Send a complete fee schedule to the State medical societies and State beneficiary associations.

January:

- Implement annual fee schedule amounts;
- Implement annual HCPCS update;
- Send an updated provider file to the Railroad Retirement Board; and
- Load MEDPARD equivalent information on the carrier Web site.

February:

- Submit participation counts to CMS Central Office via CROWD.

30.3.12.1.2 - Annual Medicare Physician Fee Schedule File Information

(Rev. 2799, Issued: 10-25-13, Effective: 01-01-14, Implementation: 01-06-14)

The CMS transmits the annual Medicare Physician Fee Schedule (MPFS) file electronically for carriers/MACs to download each year around late-October. The annual MPFS files (including anesthesia) are effective January 1st. Carriers/MACs must implement these files each January, unless otherwise directed by CMS.

NOTE: There will be an annual recurring change request for the implementation of the yearly Medicare Physician Fee Schedule Files.

The CMS will advise all contractors, via email notification, when annual MPFS files are available for download from the mainframe. Carriers/MACs can retrieve the new files and begin the process of testing and loading the new fees into the system. Carriers/MACs must place the new fees, including the anesthesia conversion factor(s), on their Web site after the MPFS final rule is placed on display. (The CMS will send notification of when the MPFS final rule is put on display via email.)

In addition, there may be last minute corrections, therefore you may have to retrieve one or more MPFS corrected files. Notification of the availability of any correction files, including the file names, will be made via an email to Carriers and MACs.

30.3.12.2 - Carrier/MACs Participation Agreement

(Rev. 2221, Issued: 05-20-11, Effective: 05-20-11, Implementation: No later October 31, 2011)

MEDICARE
PARTICIPATING PHYSICIAN OR SUPPLIER AGREEMENT

Name(s) and Address of Participant* National Provider Identifier (NPI)*

*List all names and the NPI under which the participant files claims with the Medicare Administrative Contractor (MAC)/carrier with whom this agreement is being filed.

The above named person or organization, called "the participant," hereby enters into an agreement with the Medicare program to accept assignment of the Medicare Part B payment for all services for which the participant is eligible to accept assignment under the Medicare law and regulations and which are furnished while this agreement is in effect.

1. Meaning of Assignment - For purposes of this agreement, accepting assignment of the Medicare Part B payment means requesting direct Part B payment from the Medicare program. Under an assignment, the approved charge, determined by the MAC/carrier, shall be the full charge for the service covered under Part B. The participant shall not collect from the beneficiary or other person or organization for covered services more than the applicable deductible and coinsurance.

2. Effective Date - If the participant files the agreement with any MAC/carrier during the enrollment period, the agreement becomes effective _____.

3. Term and Termination of Agreement - This agreement shall continue in effect through December 31 following the date the agreement becomes effective and shall be renewed automatically for each 12-month period January 1 through December 31 thereafter unless one of the following occurs:

a. During the enrollment period provided near the end of any calendar year, the participant notifies in writing every MAC/carrier with whom the participant has filed the agreement or a copy of the agreement that the participant wishes to terminate the agreement at the end of the current term. In the event such notification is mailed or delivered during the enrollment period provided near the end of any calendar year, the agreement shall end on December 31 of that year.

b. The Centers for Medicare & Medicaid Services may find, after notice to and opportunity for a hearing for the participant, that the participant has substantially failed to comply with the agreement. In the event such a finding is made, the Centers for Medicare & Medicaid Services will notify the participant in writing that the agreement will be terminated at a time designated in the notice. Civil and criminal penalties may also be imposed for violation of the agreement.

_____ _____ _____
Signature of participant Title Date

(or authorized representative of participating organization)

(if signer is authorized representative of organization)

Office phone number (including area code)_____

Received by (name of carrier)

Effective date _____

Initials of carrier official_____

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0373. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

30.3.12.3 - Carrier Rules for Limiting Charge

(Rev. 1, 10-01-03)
B3-17002

Effective January 1, 1991, the maximum allowable actual charge (MAAC) for non-participating physicians is replaced by the limiting charge. The limiting charge is the maximum that the non-participating provider may charge the beneficiary. It also effectively **replaces** the special charge limits for overpriced procedure, anesthesia associated with cataract and iridectomy surgery, A-mode ophthalmic ultrasound and intraocular lenses (IOLs, and designated specialty, because the limiting charge is always less than or equal to the special charge limits.

The limiting charge applies to all of the following services/supplies, regardless of who provides or bills for them, if the services/supplies are covered by the Medicare program and are provided:

- Physicians' services;
- Services and supplies furnished incident to a physician's services that are commonly furnished in a physician's office;
- Outpatient physical therapy services furnished by an independently practicing physical therapist;
- Outpatient occupational therapy services furnished by an independently practicing occupational therapist;
- Diagnostic tests; and

- Radiation therapy services (including x-ray, radium, and radioactive isotope therapy, and materials and services of technicians).

NOTE: This means that, effective for services/supplies provided on or after January 1, 1994, the limiting charge applies to drugs and biologicals provided incident to physicians' services, to physical therapy services provided by independently practicing physical therapists, and to occupational therapy services provided by independently practicing occupational therapists. These changes are made because of provisions in OBRA 1993. OBRA 1993 expanded the limiting charge to apply to services/supplies which the law permits Medicare to pay for under the physician fee schedule methodology but which Medicare has chosen to pay for under some other method. "Incident to" drugs and biologicals, previously excluded from the limiting charge because of their exclusion from physician fee schedule payment, are, effective January 1, 1994, still excluded from physician fee schedule payment but subject to the limiting charge. Also, OBRA 1993 applies the limiting charge to all of the above listed services/supplies, regardless of who provides or bills for the services/supplies. No longer are services of suppliers and other nonphysicians, such as physician assistants, nurse midwives, and independently practicing physical and occupational therapists, excluded from the limiting charge.

Physicians, non-physician practitioners, and suppliers must take assignment on claims for drugs and biologicals furnished on or after February 1, 2001, under §114 of the Benefits Improvement and Protection Act (BIPA).

Effective January 1, 1993, the limiting charge is 115 percent of the fee schedule amount for nonparticipating physicians.

EXAMPLE:

Participating fee schedule amount	$2000
Nonparticipating fee schedule amount	$1900 (95% of $2000)
Limiting charge	$2185 ($1900 times 1.15)

Charges to either a payer for whom Medicare is secondary or to a payer under the indirect payment procedure are not subject to the limiting charge if the physician accepts the payment received as full payment (i.e., if there is no payment by the beneficiary).

The provider may round the limiting charge to the nearest dollar if they do so consistently for all services.

30.3.13 – Charges for Missed Appointments

Charges for Missed Appointments

(Rev. 3510, Issued: 04-29-16, Effective: 10-01-16, Implementation; 10-03-16)

CMS's policy is to allow physicians and suppliers to charge Medicare beneficiaries for missed appointments, provided that they do not discriminate against Medicare beneficiaries but also charge non-Medicare patients for missed appointments. The charge for a missed appointment is not a charge for a service itself (to which the assignment and limiting charge provisions apply), but rather is a charge for a missed business opportunity. Therefore, if a physician's or supplier's missed appointment policy applies equally to all patients (Medicare and non-Medicare), then the Medicare law and regulations do not preclude the physician or supplier from charging the Medicare patient directly.

The amount that the physician or supplier charges for the missed appointment must apply equally to all patients (Medicare and non-Medicare), in other words, the amount the physician/supplier charges Medicare beneficiaries for missed appointments must be the same as the amount that they charge non-Medicare patients (whatever amount that may be).

With respect to Part A providers, in most instances a hospital outpatient department can charge a beneficiary a missed appointment charge without violating its provider agreement and 42 CFR 489.22. Because 42 CFR 489.22 applies only to inpatient services, it does not restrict a hospital outpatient department from imposing charges for missed appointments by outpatients. In the event, however, that a hospital inpatient misses an appointment in the hospital outpatient department, it would violate 42 CFR 489.22 for the outpatient department to charge the beneficiary a missed appointment fee.

Medicare does not make any payments for missed appointment fees/charges that are imposed by providers, physicians, or other suppliers. Charges to beneficiaries for missed appointments should not be billed to Medicare.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: PR
CARC: 204
RARC: N/A
MSN: 16.59

40 - Termination of Provider Agreement

(Rev. 1, 10-01-03)
A3-3008, A2-2800

A provider as defined in Chapter 5 of the Medicare General Information, Eligibility, and Entitlement Manual, may voluntarily terminate its participation in the program or have it terminated by the Secretary for cause.

40.1 - Voluntary Termination

(Rev. 1, 10-01-03)
A3-3008.1, A2-2800.1, RHC-330, Pub 9-124

According to 42 CFR 489.52, a provider that wishes to terminate its agreement to participate in the Medicare program may do so by: (1) filing with CMS a written notice stating its intention to terminate its agreement; and (2) informing CMS of the date upon which it wishes the termination to take effect. The CMS may approve the date proposed by the provider or set a different date no later than six months after the date of the provider's notice.

The effective date of termination may be less than six months following CMS' receipt of the provider's notice of its intention to terminate if CMS determines that termination on that date would not:

- Unduly disrupt the furnishing of services to the community; or
- Otherwise interfere with the effective and efficient administration of the Medicare program.

If a provider sends the FI a written notice of its intention to terminate its agreement, the FI should forward the notice to the CMS RO. The date of receipt of the notice by the FI will be considered the date of filing in determining the date of termination.

The RO promptly notifies the FI when it learns from other sources that a provider wishes to terminate its participation in the program, and keeps the FI informed of the status of the provider's request. It is the responsibility of the FI, as necessary, to make preliminary arrangements for filing of the cost report, and to adjust any interim payments, accelerated payments, of current financing payments to avoid overpayments. Final notice of termination of the provider's agreement is formally given to the FI by the RO via Form CMS-2007.

As soon as the termination date is established, the RO instructs the provider to notify the public that it is voluntarily terminating its provider agreement. The public notice should be published in the local newspapers with the largest circulation, as soon as possible, but not less than l5 days before the effective termination date. A provider that wishes to terminate its provider agreement should also file a Form CMS-855A with the FI requesting a voluntary termination of its Medicare billing number.

40.1.1 - Close of Business

(Rev. 1, 10-01-03)
A2-2800.2, RHC-330

A provider may temporarily or permanently cease all business (Medicare and non-Medicare), and not timely notify the RO that it is ceasing operations. The FI may be made aware very early of an impending closure due to its fiscal relationship with the

provider. Where the FI learns that a provider is ceasing operations, the FI should immediately notify the RO and also take necessary action to avert an overpayment.

A provider is considered to have voluntarily terminated its agreement if it ceases to furnish services to the community. The termination is effective after the last day of business of the provider.

40.1.2 - Change of Ownership

(Rev. 1, 10-01-03)
HHA-145, HO-145, SNF-145, RHC-331, RHC-332

When an organization having a provider agreement undergoes a change of ownership in accordance with the principles articulated in 42 CFR Part 489 and §3210 of the State Operations Manual, the agreement with the existing provider is automatically assigned to the new owner so that there is no interruption in service. However, a new agreement with updated information must subsequently be signed and a Form CMS-855A must be submitted by both the old and new owners. Only if the provider, under the change of ownership, meets the applicable requirements for approval can the agreement be executed. For FQHCs, these requirements include PHS approval.

An organization that plans to change ownership must give advance notice of its intention so that a new agreement can be negotiated or so that the public may be given sufficient notice in the event that the new owners do not wish to participate in the Medicare program. A provider that plans to enter into a lease arrangement (in whole or in part) should also give advance notice of its intention.

A change of ownership occurs, for example, when:

- A sole proprietor transfers title and property to another party;
- In the case of a partnership, there is an addition, removal, or substitution of a partner unless the partners expressly agree otherwise;
- An incorporated organization merges with an incorporated entity that is approved by the program and the latter entity is the surviving corporation. It also occurs when two or more corporate providers consolidate and the consolidation results in the creation of a new corporate entity;
- An unincorporated organization (a sole proprietorship or partnership) becomes incorporated; or
- The lease of all or part of an entity constitutes a change of ownership of the leased portion.

When an organization's agreement is terminated, whether by the entity or by CMS, no payment is available to the provider for services it furnishes to Medicare beneficiaries on or after the effective date of the termination.

40.1.3 - Expiration and Renewal-Nonrenewal of SNF Term Agreements

(Rev. 1, 10-01-03)
A3-3008.3, and Pub 100-1, Chapter 5

All agreements with skilled nursing facilities must be for a specified term of up to 12 full calendar months with fixed expiration dates unless termination occurs according to §§40.1 and 40.2. The agreement expires at the close of the last day of its specified term and is not automatically renewable from term to term. When the term of an agreement is extended (see §40.3.1), the close of the last day of its specified term is the close of the day of the extension of the agreement. Thus, when the term of an agreement is extended, the provider's participation in the program continues, and the agreement does not expire until the close of the last day to which it has been extended.

Since an agreement with an SNF is not automatically renewable from term to term, each term agreement with an SNF requires that the SNF qualify for participation and that its agreement be accepted for filing. A participating SNF may, however, continue its participation under the agreement **form** previously accepted for filing provided the SNF continues to qualify for participation, and the agreement form is again accepted for filing and renewed for a term which begins on the date immediately following the close of the last day of the prior term of the agreement. When the requirements for participation continue to be met, there is no limit to the number of times that the SNF's agreement form may again be accepted and renewed for a specified term.

When the time-limited agreement (including an agreement which has had its term extended) is renewed on the day immediately following the close of the last day of its term, the expiration of the agreement is not considered a termination of participation in the program.

However, once an agreement with an SNF is (1) not renewed, or (2) voluntarily terminated by the SNF, or (3) involuntarily terminated (including cancellations) by the Secretary, the previously accepted agreement cannot again be accepted and renewed. In such cases, the SNF is required to execute and file a new agreement if it is again found eligible to participate in the Medicare program and must submit a Form CMS-855A as a **brand new provider**. The effective date of the new agreement must be determined in accordance with regulatory provisions (42 CFR 489.13).

The Secretary's determination not to accept and renew a SNF agreement is a determination relating to the qualifications of the SNF in the period immediately following the close of the SNF's existing agreement; and the SNF is entitled to request a reconsideration of the determination in accordance with the appeals procedure contained in 42 CFR Part 405 Subpart O. Such determinations involve a finding that:

- Based on a State agency resurvey and recertification, the SNF will not be approved for a period of certification because it is out of compliance with one or more conditions of participation;

- Based on a State agency resurvey and recertification, the SNF continues to be out of compliance with the same standard(s) in the conditions of participation as were found out of compliance during the term of the agreement and the facility will not be approved for a new period of certification; or

- The SNF has violated the terms of its agreement or the provisions of title XVIII or regulations promulgated thereunder.

In cases of nonrenewal by the Secretary, the FI's role is the same as for involuntary terminations. (See §40.2.1).

40.2 - Involuntary Terminations

(Rev. 1, 10-01-03)
A3-3008.2, RHC-331

The Secretary may terminate an agreement with a provider if it is determined that the provider:

- Is not complying fully (or substantially in the case of SNFs) with the provisions of the agreement or with the applicable provisions of title XVIII of the Act and regulations;

- No longer meets the appropriate conditions (requirements for SNFs) of participation;

- Has failed to supply information which is necessary to determine whether payments are due or were due and the amounts of such payments; or

- Refuses to permit examinations of fiscal and other records, including medical records.

The cancellation of a SNF agreement is viewed as an involuntary termination of the agreement by the Secretary for cause. Such actions involve a finding that the SNF has not satisfactorily completed its written plan providing for the correction of deficiencies with respect to one or more of the standards in the applicable requirements of participation, or that the facility has not made substantial effort and progress in correcting such deficiencies.

A provider which is dissatisfied with the Secretary's determination terminating its agreement is entitled to request a hearing thereon in accordance with the appeals procedures contained in 42 CFR Part 498. There is **no** reconsideration step before the opportunity for a hearing.

For the FI's role in processing involuntary terminations, see §40.2.1.

NOTE: The involuntary termination of a hospital's approval authorizing it to provide extended care services, i.e., to be a swing bed facility, (see Chapter 3) does not automatically result in the involuntary termination of the hospital's agreement relating to the provision of hospital services.

40.2.1 - Processing Involuntary Terminations

(Rev. 1, 10-01-03)
A2-2800.3

When there has been a determination by the RO that an institution or agency no longer qualifies as a provider of services, the RO notifies the provider in writing that termination of its agreement has been recommended. A copy of this notification is sent to the servicing FI so that it is aware of the potential termination. However, the FI should not divulge this information.

If CMS central office decides that termination of the agreement is appropriate, it establishes the effective date of termination, notifies the provider in writing, and notifies the RO. The RO immediately arranges for publication of the required notice to the public and sends a formal notice of termination to the FI via Form CMS-2007 (see §40).

40.2.2 - FI Report on Provider Deficiencies

(Rev. 1, 10-01-03)
A2-2801, A2-2801.1

Most terminations of provider agreements are based primarily on health and safety factors, but fiscal considerations may also play an important role in the decision to terminate. The provider agreement and the Social Security Act impose certain obligations on the provider with respect to costs, charges, financial records, and related matters.

Deficiencies in these areas may, of themselves, or in the combination with deficiencies in health and safety factors, constitute significant reasons for termination.

Upon receipt of a State agency recommendation of termination, the RO notifies the servicing FI and requests a report concerning any reimbursement aspects that might constitute additional grounds for termination. The FI's report should include such information as: cost reports not filed; cost reports past due and a description of the action taken; the provider's refusal to permit the necessary examination of its fiscal records; status of any cost report settlements still pending; provisions for recoupment of current financing and accelerated payments; amount of unpaid billings for covered services rendered which may be used as an offset against any overpayment; and any potential overpayment in the current period.

40.2.2.1 - Subsequent Communications With Provider

(Rev. 1, 10-01-03)
A2-2801.2

Following release of the report to the RO, any communication between the provider and the FI related to reimbursement or other problems that could constitute grounds for termination should be immediately reported to the RO. The RO should also be informed **in advance** of any subsequent onsite visits to the provider regarding such matters. Unrecorded communications, visits, or correctional allegations that were not known and taken into consideration by CMS before final termination may cause embarrassment or even result in failure to sustain the termination action at later stages of the proceedings, particularly if the issue goes to a formal hearing. Even after final termination action, any such contacts with the provider may be pertinent to proper handling of the case by CMS, and therefore the FI must promptly forward the information to the RO.

40.3 - Readmission to Medicare Program After Involuntary Termination

(Rev. 1, 10-01-03)
A2-2804

After the involuntary termination of its agreements, a health facility cannot participate again as a provider unless:

- The reasons for termination of the prior agreement have been removed, and
- There is reasonable assurance that they will not recur.

The RO makes the final decision as to whether the facility is eligible for readmission. In doing so, it reviews the case in its entirety and makes the final decision regarding the following:

- Correction of deficiencies upon which the termination was based;
- Reasonable assurance of continued compliance, and
- Reasonable assurance of availability of information pertinent to reasonable cost reimbursement.

The RO will then process the case in the same way as an initial certification.

40.3.1 - Effective Date of Provider Agreement

(Rev. 1, 10-01-03)
A2-2804.1

Since one of the key issues is whether the facility has furnished “reasonable assurance” that the reasons for termination will not recur, the provider agreement cannot be effective before the date on which “reasonable assurance” is deemed to have been provided.

Generally, a facility will be required to operate for a period of 60 days without recurrence of the deficiencies that were the basis for the termination. The provider agreement will be effective with the end of the 60-day period. If corrections were made before filing the new request for participation, the period of compliance before filing the new request will be counted as part of the 60-day period; however, in no case can the effective date of the provider agreement be earlier than the date of the new request for participation.

Exceptions to the 60-day period of compliance will be made where:

- Structural changes have eliminated the reasons for termination. “Reasonable assurance” will be considered established as of the date such structural changes were completed. The effective date will be that date or the date of filing the new request to participate, whichever is later.

- "Reasonable assurance” is not established even after 60 days of compliance, because of the facility’s history of misrepresentation or of making temporary corrections and then relapsing into the old deficiencies that were the basis for termination. The effective date in such cases would be the earliest date after 60 days at which “reasonable assurance” is deemed to have been established, or the filing date of the new request to participate, whichever is later.

40.3.2 - Fiscal Considerations in Provider Readmission to Medicare Program After Involuntary Termination

(Rev. 1, 10-01-03)
A2-2805, RHC-334

Upon being notified that a terminated provider has filed a request for participation, the RO telephones the FI which previously serviced the facility and requests information concerning any unresolved financial problems (e.g., an overpayment that must be recovered) so that the RO can determine whether such issues must be resolved before the facility is permitted to participate.

The RO also contacts the FI that will service the facility upon readmission (this may be either the FI which previously serviced the facility or another FI) and asks it to make sure that the facility has made adequate provisions for furnishing the financial and accounting data required under the participation agreement. Where termination was based on fiscal considerations, either entirely or in combination with deficiencies in health and safety factors, the FI will also be requested to check and report on whether the deficiencies have been corrected. This report should include:

- The basis for believing that the deficiencies that led to termination of the provider agreement have (or have not) been corrected.

- If corrected, a description of:

- When and how this was done;
- The evidence showing compliance has existed for a sufficient period of time; and
- The FI's reasons for concluding that the deficiencies will not recur.

- A description of any other fiscal and reimbursement problems and the basis of believing these should (or should not) affect certification of the facility.

40.4 - Payment for Services Furnished After Termination, Expiration, or Cancellation of Provider Agreement

(Rev. 980, Issued: 06-14-06, Effective: 10-01-06, Implementation: 10-02-06)

The CMS RO will inform the FI upon termination, expiration or cancellation of a provider agreement.

Effective with the date a provider agreement under §1866 of the Act (or swing bed approval) terminates, expires, or is cancelled, no payment is made to the provider under such agreement for:

A Termination of Hospital Agreement

Inpatient hospital services (including inpatient psychiatric hospital services) and swing bed extended care services furnished on or after the effective date of the hospital's termination, except that payment can continue to be made for up to 30 days of inpatient hospital services and/or swing bed extended care services (total of no more than 30 days) furnished on or after the termination date to beneficiaries who were admitted (at either the acute or extended care level) prior to the termination date.

B Termination of Swing Bed Approval

Swing bed extended care services furnished on or after the effective date of the termination of the hospital's swing bed approval, except that payment can continue for up to 30 days of extended care services furnished on or after the termination date to beneficiaries who were admitted (at either the acute or extended care level) prior to the termination date.

C Skilled Nursing Facility Termination

Posthospital extended care services furnished on or after the effective date of termination of the agreement, where such agreement has been voluntarily terminated by the provider (§40.1) or involuntarily terminated by the Secretary for cause (§40.2). However, payment can continue to be made for up to 30 days of posthospital extended care services furnished on and after the termination date to beneficiaries who were admitted prior to the termination date.

D Expiration SNF

Posthospital extended care services furnished on or after the date which follows the last day of the specified term of the agreement, where such agreement has expired at the close of the last day of its specified term (§40.3), except that where the agreement has not been renewed, payment can be made for up to 30 days of posthospital extended care services furnished on and after the date which follows the last day of the specified term of such agreement to beneficiaries who were admitted on or before such last day.

E HHA and Hospice

Home health and hospice services furnished under a plan which is established on or after the termination date, except that if the plan was established before the termination date, payment is made for services for up to 30 days following the effective date of termination.

F Other

Other items and services, including outpatient physical therapy or speech-language pathology and diagnostic services, furnished on or after the effective date of termination or, in the case of an expiration or cancellation of an SNF agreement, on or after the day following the close of such agreement.

40.4.1 - Reviewing Inpatient Bills for Services After Suspension, Termination, Expiration, or Cancellation of Provider Agreement, or After a SNF is Denied Payment for New Admissions

(Rev. 1, 10-01-03)
A3-3600.3

See §40.4 for provisions for payment following a termination or expiration of a provider agreement. A SNF may be denied payment for new admissions, but not readmissions, as an option to termination of its provider agreement for noncompliance with one or more requirements of participation. The SNF may only be reimbursed for covered services furnished **on or after the effective date of denial of payments** if such services were furnished to beneficiaries who were admitted to the SNF before the effective date of termination or expiration.

EXAMPLE:

Effective date of denial of payment - 9-30

Beneficiary admitted before 9-30 - pay for covered Part A or B services

Beneficiary admitted on or after 9-30 - deny payment under Part A or B

NOTE: An inpatient who goes on leave from the SNF before or after the effective date of denial of payments for new admissions is not considered a new admission when returning from leave.

The contractor is notified of SNF payment denials through the Form CMS-2007. It must install appropriate edits or other safeguards to prevent incorrect payments to the provider.

The contractor obtains a list of Medicare inpatients when a SNF or hospital agreement is terminated, or after a SNF is denied payment for new admissions to assure that nonpayment spell of illness bills are filed.

40.4.2 - Status of Hospital or SNF After Termination, Expiration, or Cancellation of Its Agreement

(Rev. 1, 10-01-03)
A3-3699.3.C

Following termination, expiration, or cancellation of its agreement, a hospital or SNF is considered to be a "nonparticipating provider." An inpatient of such an institution who has Part B coverage, but for whom Part A benefits have been exhausted or otherwise not available, is entitled to reimbursement only for services that are covered in a nonparticipating institution. A patient admitted to the SNF on or after the effective date of denial of payment who has Part B coverage is entitled to reimbursement for services covered in a nonparticipating institution. Such services furnished on or after the effective date of termination, or in the case of expiration or cancellation of an SNF agreement, on or after the day following the close of such agreement, are billed on Form CMS-1500, Health Insurance Claim Form, and sent to the carrier.

A terminated hospital may be certified to provide emergency services. If it meets the criteria, it is assigned an emergency provider number (E suffix). This procedure is not automatic, and hospitals terminated for Life Safety Code violations may not be able to qualify. If a terminated hospital qualifies, the designated emergency FI handles billings as follows:

Region I	Associated Hospital Services of Maine (dba, Maine Blue Cross and Blue Shield
Region III	Veritus
Region IV	First Coast Services
Region VI	Trailblazers
Region VII	Blue Cross and Blue Shield of Nebraska
Region IX	United Government Services

Regions II, V, VIII, and X have no designated FI.

Claims for services provided in a Religious Nonmedical Healthcare Institutions (domestic and foreign) are sent to Riverbend Government Benefits Administrator (GBA) in Tennessee.

The following CMS Web address provides a complete list of addresses and phone numbers for FIs and carriers: http://cms.hhs.gov/contacts/incardir.asp**.**

In a no-payment situation, where the entire billing period represents charges for which no Part A payment can be made, it is not necessary for the provider to submit two bills. The provider submits only a final no-payment bill, with a discharge date, under the former provider number.

Services furnished during the "no-payment" period may subsequently be determined to be covered. Where such covered services were furnished **before** the date of change in provider number, the provider submits one corrected bill covering the entire period showing the former provider number. Where the services were furnished **after** the date of change in provider number or both **before and after** the date of change, the provider submits a corrected discharge bill.

40.5 - FI/Carrier/DMERC Responsibilities for Informing Providers of Changes

(Rev. 1, 10-01-03)
A3-3600.7

Contractors must inform providers in writing of changes in policy and procedures and the effective date before making changes. They must send these notices at least thirty days before changes are put into effect to give providers time to adjust. When a shorter implementation schedule is unavoidable, the contractor must provide the notice as soon as it is available.

For electronic data interchange (EDI) instructions, the contractor must notify providers of changes at least 60 to 90 days in advance.

Contractors must conduct provider training on an as needed basis and initiate regular contact with the provider community through organizations that represent them. It must develop continuing staff contacts with these organizations to resolve issues of mutual concern.

The contractor must provide adequate telephone service so that providers can receive prompt answers to claims status and processing questions. It must implement procedures and training in telephone units to ensure that its employees furnish consistent and correct information and make appropriate referrals for specialized information.

50 - Filing a Request for Payment With the Carrier or FI

(Rev. 1, 10-01-03)
A3-3301

Except as provided in §50.1.2 and §50.1.6, payment may not be made for Medicare services furnished under Part A or Part B unless the beneficiary or a designated

representative files a timely written request for payment and the provider files a timely claim. (See §§80 for an explanation of time limits.)

If the beneficiary does not file a request upon admission or start of care, it may be filed later with the provider or (less preferably) with an FI or carrier or CMS. The provider still must file a claim for payment (billing).

50.1 - Request for Payment From the Carrier or FI

(Rev. 1, 10-01-03)
A3-3302

50.1.1 - Billing Form as Request for Payment

(Rev.: 4388; Issued: 09-06-19; Effective: 10-07-19; Implementation: 10-07-19)

Each of the paper billing forms--CMS-1500-- Health Insurance Claim Form; and CMS-1490S-- Patient's Request for Medical Payment,)-- contains a patient's signature line or reference to the patient signature incorporating the patient's request for payment of benefits, authorization to release information, and assignment of benefits. When the billing form is used as the request for payment, there must be a signature, except when the provisions in §50.1.2 apply.

The Medicare Uniform Institutional Provider Bill, Form CMS-1450, does not contain a line for the patient's signature. As a result, the billing form itself cannot be used as a request for payment. Requests for payment must be obtained and retained in the provider's records. The institutional claim form contains a provider representative signature, which includes a certification that a request for payment has been obtained from the patient. See §50.1.2 for requirements for providers.

Electronic billing is required except when an exception is possible under ASCA. See §2 of this chapter for related information.

50.1.2 - Beneficiary Request for Payment on Provider Record - ASC X12 837 Institutional Claims

(Rev. 4201, Issued: 01-18-19, Effective: 02-19-19, Implementation: 02-19-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

A participating provider (hospital, critical access hospital, skilled nursing facility, home health agency, outpatient physical therapy provider, or comprehensive outpatient rehabilitation facility), ESRD facility, Independent rural health clinic, freestanding Federally Qualified Health Clinic, Religious Nonmedical Health Care Institution, or

Community Mental Health Centers must use a procedure under which the signature of the patient (or his representative) on its records will serve as a request for payment for services of the provider.

To implement this procedure the provider must incorporate language to the following effect in its records:

Request for Payment

_____ _____

NAME OF BENEFICIARY Medicare beneficiary identifier

I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by or in (name of provider). I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

For services furnished to inpatients of a hospital, or SNF, the request is effective for the period of confinement. For services furnished by an HHA under a plan of treatment the request is effective for the plan of treatment. For other services the request is effective until revoked. If a patient objects to part of the request for payment, the provider should annotate the statement accordingly.

In using this procedure, the provider undertakes to make the patient signature files available for A/B MAC (A and B) inspection on request.

The A/B MAC (A and B) must make periodic audits of signature files selected on a random basis. The A/B MAC (B) may arrange with the A/B MAC (A) for the latter to perform this function on its behalf for A/B MAC (B) claims submitted by providers.

50.1.3 - Signature on the Request for Payment by Someone Other Than the Patient

(Rev. 2984, Issued: 07-11-14, Effective: 08-12-14, Implementation: 08-12-14)

General

If at all practical the patient should sign the request on the provider's records at the start of care, or upon admission for hospital or SNF admissions. However, where a beneficiary is unable to execute a request for payment because of a mental or physical condition, the request may be executed on his/her behalf by a legal guardian, representative payee (a person designated by the Social Security Administration or other governmental agency to receive an incompetent beneficiary's monthly cash benefits), relative, friend, representative of an institution providing him/her care or support, or of a governmental agency providing assistance. A physician or supplier (or his/her employee) cannot request payment for services furnished except under circumstances fully documented to show that the enrollee is unable to sign and that there is no other person who could.

For this purpose, "an institution providing him/her care" includes a long-term care facility, a hospital (whether psychiatric or general), a SNF, and a nursing home. Only an employee of the institution or agency may be authorized to act as its representative to sign claims on behalf of incompetent patients.

The name of the incompetent person should be shown on the signature line of the Request for Medicare Payment (or equivalent authorization retained in the file, followed by "by" and the signature of the requestor. The requestor, other than a representative payee, should attach a statement to the Request for Medicare Payment explaining his/her relationship to the beneficiary and the reason the beneficiary cannot sign. If such a statement is not submitted, A/B MACs must obtain an explanation if other development is needed or if the physician or supplier (or employee) has signed. Except in such cases, A/B MACs should not delay processing the claim to obtain an explanation.

A/B MACs are permitted to honor an otherwise properly completed and submitted claim signed by the administrator (or other authorized employee) of a nonprofit long-term care facility on behalf of a resident who has given the facility the necessary power of attorney (P/A). (A long-term care facility, as distinguished from a nursing or other SNF, is an institution that contractually provides room, board, medical, and other necessary services to people who commonly enter and remain there for life, even when in good health. It may include a skilled nursing unit.) A/B MACs may assume that the facility has the necessary authority when the administrator enters in the signature space the resident's name, followed by "P/A," the administrator's signature, his title, and the name of the home. A signature on behalf of a competent enrollee based on a P/A granted to anyone other than an authorized official of a nonprofit long-term care facility is not acceptable.

NOTE: The fact that such a request may be honored does not mean that payment can be made to the requestor.

In certain circumstances, it would be impracticable for an individual to sign the request for payment himself because when he is admitted to a hospital or skilled nursing facility or first receives outpatient or home health services, he is unconscious, incompetent, in great pain, or otherwise in such a condition that he should not be asked to transact any business. In such a situation, his representative payee (i.e., a person designated by the Social Security Administration to receive monthly benefits on the patient's behalf), a relative, legal guardian, or a representative of an institution (other than the provider) usually responsible for his care, or a representative of a governmental entity providing welfare assistance, if present at time of admission, should be asked and permitted to sign on his behalf.

A. Provider Signs Request

If, at the time of admission, the patient cannot be asked to sign the request for payment and there is no person present exercising responsibility for him, an authorized official of the provider may sign the request. Except in the outpatient case described below, where

the patient is not physically present, a provider should not routinely sign the request on behalf of any patient. If experience reveals an unusual frequency of such provider-signed request from a particular provider, the matter will be subject to review by the A/B MAC (A).

The hospital or SNF need not attempt to obtain the patient's signature where the physician sends a specimen (e.g., blood or urine sample) to a laboratory of a participating hospital or SNF for analysis, the patient does not go to the hospital or SNF, but the tests are billed through that provider. The hospital or SNF may sign on behalf of the patient and should note in its records "Patient not physically present for tests." This does not apply in cases in which the patient actually goes to the hospital or SNF laboratory for tests and the provider fails to obtain the patient's signature while he is there.

If it is impractical to obtain the patient's signature because a home health agency does not make a visit to his home (e.g., the physician certifies that the patient needs a certain item of durable medical equipment but no visits are certified), the agency may furnish the equipment and need not obtain the patient's signature. An agency representative should sign on behalf of the patient and indicate in the provider record "Patient not visited."

B. Patient Dies

If the patient dies before the request for payment is signed, it may be signed by the legal representative of the estate, or by any of the persons or institutions (including an authorized official of the provider) who could have signed it had the patient been alive and incompetent.

A request for payment for inpatient hospital services filed with the hospital may serve as an application for HI entitlement when filed by or on behalf of a live patient, but **not** when filed on behalf of a deceased patient. See §50.1.4.

C. Need for Explanation of Signer's Relationship to Patient

When someone other than the patient signs the request for payment, the signer will submit a brief statement explaining the relationship to the patient and the circumstances which made it impracticable for the patient to sign. The provider will retain the statement in its files. The A/B MAC (A) will generally accept such a statement as representing the true facts of the case in the absence of evidence to the contrary. If development is needed for some other reason, the A/B MAC (A) will ask the provider to furnish the explanation of relationship and circumstances. However, processing the claim should not ordinarily be delayed to obtain the explanation if nothing else prevents payment.

50.1.4 - Request for Payment as a Claim for HI Entitlement

(Rev. 1, 10-01-03)
A3-3302.6

To become entitled to hospital insurance, an individual must not only be eligible, but must also, prior to his death, apply for such entitlement (or for monthly social security benefits) with the Social Security Administration (SSA). Even though an individual meets all eligibility requirements, if the necessary application is not filed before death, the individual cannot be entitled to Part A benefits and no payment can be made under the HI program for hospital services.

Occasionally a patient aged 65 or over who is admitted to a hospital, though eligible, has never applied for monthly benefits and has no health insurance card. In very rare instances the patient may have a card even though the necessary application has not been filed. To protect the eligible patient, the estate, and the hospital against the possibility that timely application will not be filed with SSA, a written request for title XVIII payment filed with the hospital may serve as an application for hospital insurance entitlement filed with SSA. The request must be filed with the hospital prior to the death of the patient. A prescribed application form properly executed must be filed with SSA within six months of the date of SSA's written notice to a proper applicant of the need for such application. Chapter 2 contains the details of this procedure.

This function of the written request as an informal claim for HI entitlement under certain conditions is distinct from its far more general and basic function as a request that payment may be made on behalf of an entitled individual to the provider. A request for payment in this latter sense can validly be executed after the death of the entitled individual.

50.1.5 - Refusal by Patient to Request Payment Under the Program

(Rev. 1, 10-01-03)
A3-3302.7

A patient on admission to a hospital or skilled nursing facility may refuse to request Medicare payment and agree to pay for the services out of their own funds or from other insurance. Such patients may have a philosophical objection to Medicare or may feel that they will receive better care if they pay for services themselves or they are paid for under some other insurance policy. The patient's impression that another insurer will pay for the services may or may not be correct, as some contracts expressly disclaim liability for services covered under Medicare. Where the patient refuses to request Medicare payment, the provider should obtain a signed statement of refusal wherever possible. If the patient (or his representative) is unwilling to sign, the provider should record that the patient refused to file a request for payment but was unwilling to sign the statement of refusal.

In any event, there is no provision that requires a patient to have covered services paid for under Medicare if the patient refuses to request payment. Therefore, a provider may bill an insured patient who positively and voluntarily declines to request Medicare payment. However, if such a person subsequently requests payment by Medicare (because another insurance will not pay or for another reason) and requests payment under the health insurance program within the prescribed time limit, the provider must submit a Medicare

claim, and refund to the patient any amounts the beneficiary paid in excess of the permissible charges.

Where a patient who has declined to request payment dies, the right to request payment may be exercised by the legal representative of the estate, by any of the persons or institutions mentioned in the second paragraph of §50.1.3, by a person or institution which paid part or all of the bill, or in the event a request could not otherwise be obtained, by an authorized official of the provider. This permits payment to the provider for services that would not otherwise be paid for and allows a refund to the estate or to a person or institution that paid the bill on behalf of the deceased.

See §70 for filing claims for payment and for associated time limits.

The provider may charge the beneficiary for covered services where the beneficiary refuses to file.

50.1.6 - When Beneficiary Statement is Not Required for Physician/Supplier Claim

(Rev. 980, Issued: 06-14-06, Effective: 10-01-06, Implementation: 10-02-06)

A. Enrollee Signature Requirements

A request for payment signed by the enrollee must be filed on or with each claim for charge basis reimbursement except as provided below. All rules apply to both assigned and unassigned claims unless otherwise indicated.

1. When no enrollee signature required:

    a. Claim submitted for diagnostic tests or test interpretations performed in a medical facility which has no contact with enrollee.

    b. Unassigned claim submitted by a public welfare agency on a bill which is paid.

    c. Enrollee deceased, bill unpaid and the physician or supplier agrees to accept Medicare approved amount as the full charge.

2. When signature by mark is permitted: The enrollee is unable to sign his name because of illiteracy or physical handicap.

3. When another person may sign on behalf of the enrollee:

    a. Enrollee who is resident of a nonprofit retirement home gives power of attorney to the administrator of the home.

b. Enrollee physically or mentally unable to transact business: The request may be signed by a representative payee, legal representative, relative, friend, representative of an institution providing the enrollee care or support, or of a governmental agency providing him/her assistance.

c. Enrollee physically or mentally unable to transact business and full documentation is supplied that the enrollee has no one else to sign on his behalf: The physician, supplier, or clinic may sign.

d. Enrollee deceased and bill paid or liability assumed: Person claiming payment should sign. If Form CMS-1500 was signed before the enrollee dies, claimant should sign separate request for underpayment.

4. When request retained in file may cover extended future period:

a. Assignment in files of welfare agency covers all services furnished during the period when the enrollee is on medical assistance.

b. Authorization in files of organization approved under §30.2.8.3 covers all services paid for by that organization under that procedure.

c. Assignment in the files of group practice prepayment plan covers services furnished by the plan during the period of the enrollee's membership.

d. Assignment in the files of a participating provider (hospital, SNF, home health agency, outpatient physical therapy or speech-language pathology provider or comprehensive rehabilitation facility) or ESRD facility covers physician services for which the provider or facility is authorized to bill, and may cover the physician services furnished in the provider or facility as follows:

- Inpatient services - effective for period of confinement.
- Outpatient services - effective indefinitely.

e. Assignment in files of individual physician, supplier (except in the case of unassigned claims for rental of durable medical equipment) or qualified reassignee under §30.2 is effective indefinitely.

B. Physician (Supplier) Signature Requirement

The rules below apply to both assigned and unassigned claims unless otherwise indicated.

1. In a claim for services furnished by an individual physician (or supplier), the physician may:

a. In an unassigned claim, provide an itemized bill on his own letterhead - no physician signature required. A Form CMS-1500 on which the name or

identification code of the physician has been stamped or preprinted in item 31 is the equivalent of the physician's own letterhead.

b. Sign item 31 of Form CMS-1500.

c. Sign one time certification letter for machine-prepared claims submitted on other than paper vehicles.

d. Authorize an employee (e.g., nurse, secretary) to enter the physician's signature in item 31 of the Form CMS-1500.

   i. Manually
   ii. By stamp-facsimile or block letters
   iii. By computer

e. Authorize a nonemployee agent, e.g., billing service or association, to enter as in d. above, the physician's signature in item 31 of the Form CMS-1500, followed by the agent's name, title, and organization (e.g., a billing agent might enter by stamp "Dr. Tom Jones by Robert Smith, Secretary, Ajax Billing Service"). Alternatively, the agent may simply enter the physician's signature.

2. In a claim by a clinic, hospital, or other entity authorized to bill and receive payment in its name for the services of the physician, the entity may:

   a. In an unassigned claim, provide an itemized bill on its letterhead-no signature necessary. A Form CMS-1500 on which the name or identification code of the billing entity has been stamped or preprinted in item 8 is the equivalent of the reassignee's own letterhead.

   b. Have authorized official sign in item 25 of the Form CMS-1500 (item 13 of Form CMS-1554, item 6 of Form CMS-1556).

   c. Have authorized official sign one-time certification letter for machine-prepared claims submitted on other than paper vehicles.

   d. Have authorized employee, e.g., a secretary, enter authorized official's signature in item 25 of the Form CMS-1500 (item 13 of Form CMS-1554, item 6 of Form CMS-1556) as in 1d.

   e. Have nonemployee agent enter authorized official's signature in item 25 of the Form CMS-1500 (item 13 of Form CMS-1554, item 6 of Form CMS-1556) as in 1.e.

50.1.7 - Definition of a Claim for Payment

(Rev. 3086, Issued: 10-03-14, Effective: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012, Implementation ICD-10: Upon Implementation of ICD-10; ASC X12: November 4, 2014)

For those billing A/B MACs (B) and DME MACs, a claim does not have to be on a form but may be any writing submitted by or on behalf of a claimant, which indicates a desire to claim payment from the Medicare program in connection with medical services of a specified nature furnished to an identified enrollee. It is not necessary that this submission be recorded on a CMS claim form, that the services be itemized or that the information submitted be complete (e.g., a note from the enrollee's spouse, or a bill for ancillary services in a nonparticipating hospital, could count as a claim for payment).

The writing must contain sufficient identifying information about the enrollee to permit the obtaining of any missing information through routine methods, e.g., file check, microfilm reference, mail or telephone contact based on an address or telephone number in file. Where the writing is not submitted on a claims form, there must be enough information about the nature of the medical or other health service to enable the contractor with claims processing jurisdiction to determine that the service was apparently furnished by a physician or supplier.

The definition of a part B claim for purposes of timely filing is any writing submitted by or on behalf of a claimant, which indicates a desire to claim payment from the Medicare program for medical services of a specified nature to an identified enrollee. For example, a note from the enrollee's spouse or a bill for ancillary services in a nonparticipating hospital could constitute a claim for payment.

If such a claim is mailed or delivered to SSA, CMS or to any A/B MAC (A or B) within the time limit, the claim is filed timely provided the necessary claims information (e.g., Form CMS-1490S and itemized bill in the case of an enrollee-filed claim) is submitted within the time limit or, if later, within six months after the end of the month in which the claimant is advised to furnish it, e.g., if the notice is provided February 2, the claim must be filed by close of business August 31. See Statement of Intent instructions in §70.7.

Note that electronic claims must be in the appropriate HIPAA standard format. Refer to section 2 of this chapter as well as chapters 24 and 25 for more information.

50.1.8 - Establishing Date of Filing - Postmark Date - Carriers

(Rev. 1, 10-01-03)
A3-3305.2, A3-3305.3

Whenever the last day for timely filing of a claim falls on a Saturday, Sunday, legal holiday, or other day all or part of which is a non-work-day for Federal employees because of Federal statute or executive order, the claim will be considered timely if it is filed on the next workday.

Where the claim is submitted to the carrier by mail, if it is material and to the advantage of the provider, the claim can be considered filed on the day the envelope was postmarked in the United States. Thus, where an undated claim is received by the carrier in the mail early in the month after the filing date, the envelope should, if practical, be retained. If, in such a case, an envelope with a legible postmark is not available, a 7-day tolerance will usually apply. For example, a claim for services provided in May 2000 received by a carrier on or before January 10, 2002, may be presumed by the carrier, in the absence of evidence to the contrary, to have been mailed on or before January 2, 2002, (which is the date the time limit expires because it is the first Federal workday after Saturday, December 31). This rule will be applicable where the claim was mailed within the contiguous 48 States and the District of Columbia and received by a carrier within such States. In other cases, the reasonable tolerance may be longer and will depend on the usual mailing time under the particular circumstances.

50.2 - Frequency of Billing for Providers

(Rev. 1231; Issued: 04-27-07; Effective: 12-03-07; Implementation: 12-03-07)

Different types of providers are paid based on different payment policies depending upon the circumstance of the provider. These payment policies are described in detail in the chapters related to the provider type. The following billing requirements are to strike a balance between program administration efficiency and maintaining cash flow for providers.

Standard System Maintainer (SSM) shall ensure that providers adhere to these requirements.

50.2.1 – Inpatient Billing From Hospitals and SNFs

(Rev. 13725; Issued: 04-10-26; Effective: 10-01-26; Implementation: 10-05-26)

Non PPS Hospitals and SNFs

Inpatient services in TEFRA hospitals (i.e., hospitals excluded from inpatient prospective payment system (PPS), cancer and children's hospitals) and SNFs are billed:

- Upon discharge of the beneficiary;
- When the beneficiary' benefits are exhausted;
- When the beneficiary's need for care changes; or
- On a monthly basis.

Hospitals in Maryland that are under the jurisdiction of the Health Services Cost Review Commission are subject to monthly billing cycles.

Providers shall submit a bill to the FI when a beneficiary in one of these hospitals ceases to need a hospital level of care (occurrence code 22). FIs shall not separate the occurrence code 31 and occurrence span code 76 on two different bills. Each bill must include all applicable diagnoses and procedures. However, interim bills are not to include

charges billed on an earlier claim since the "From" date on the bill must be the day after the "Thru" date on the earlier bill.

SNF providers shall follow the billing instructions provided in Chapter 6 (SNF Inpatient Part A Billing), Section 40.8 (Billing in Benefits Exhaust and No-Payment Situations) for proper billing in benefits exhaust and no-payment situations.

PPS Hospitals

Inpatient acute-care PPS hospitals, inpatient rehabilitation facilities (IRFs), long term care hospitals (LTCHs) and inpatient psychiatric facilities (IPFs) may interim bill in at least 60-day intervals. Subsequent bills must be in the adjustment bill format. Each bill must include all applicable diagnoses and procedures.

All inpatient providers will also submit a bill when the beneficiary's benefits exhaust. This permits them to bill a secondary insurer when Medicare ceases to make payment. Initial inpatient acute care PPS hospital, IRF, IPF and a LTCH interim claims must have a patient status code of 30 (still patient). When processing interim PPS hospital bills, providers use the bill designation of 112 (interim bill - first claim). Upon receipt of a subsequent bill, the FI must cancel the prior bill and replace it with one of the following bill designations:

- For subsequent interim bills, bill type 117 with a patient status of 30 (still patient); or

- For subsequent discharge bills, bill type 117 with a patient status other than 30. (See Chapter 25 for a list of valid patient discharge status codes)

All inpatient providers must submit bills when any of the following occur, regardless of the date of the prior bill (if any):

- Benefits are exhausted;
- The beneficiary ceases to need a hospital level of care (all hospitals);
- The beneficiary falls below a skilled level of care (SNFs and hospital swing beds); or
- The beneficiary is discharged.

Effective December 3, 2007, when a beneficiary's Medicare benefits exhaust in an IPF or an LTCH, the hospital is allowed to submit a no pay bill (TOB 110) with a patient status code 30 in 60 day increments until discharge. They no longer have to continually adjust bills until physical discharge or death. The last bill shall contain a discharge patient status code.

Examples:

- *Submit a claim for admission through day 60: TOB 112 (interim bill – first claim); patient status code 30 (still patient).*
- *Submit subsequent claims every 60 days until benefits exhaust: TOB 117 (adjustment); patient status code 30 (still patient).*
- *Submit no pay claims every 60 days after benefits exhaust: TOB 110 (no pay); patient status code 30 (still patient).*
- *Submit a final claim upon physical discharge or death: TOB 110 (no pay); appropriate patient status code (other than 30).*

These instructions for hospitals and SNFs apply to all providers, including those receiving Periodic Interim Payments (PIP). Providers should continue to submit no-pay bills until discharge.

Effective for discharges on or after 10/01/2024, a new system-generated adjustment shall enforce correct PPS hospital interim billing procedures by rejecting finalized interim claims (excluding TOB 110) reporting patient status 30 (still patient), no benefits exhaust coding is reported, and the claim has been finalized for payment without adjustment or cancel for 90 days or greater. Providers should rebill the stay from admit through discharge, or current service dates if the patient is still confined, and must include current utilization of benefit days, and the appropriate patient status code at the time of claim re-submission.

MACs (A) shall use the following remittance advice and MSN messaging when rejecting claims for failure to update patient status and service dates:

Group Code: CO
CARC: 16
RARC: MA31, MA43
MSN: 16.71, 31.9

NOTE: For stays that necessitate the reporting of more than ten OSCs (i.e., more OSCs than the claim formats allow), Long Term Care Hospitals, Inpatient Psychiatric Facilities, and Inpatient Rehabilitation Facilities shall refer to instructions provided in Chapter 32, section 74.3 of this manual.

50.2.2 - Frequency of Billing for Providers Submitting Institutional Claims with Outpatient Services

(Rev. 2092, Issued: 11-12-10, Effective: 04-01-11, Implementation: 04-04-11)

Repetitive Part B services furnished to a single individual by providers that bill institutional claims shall be billed monthly (or at the conclusion of treatment). The instructions in this subsection also apply to hospice services billed under Part A, though they do not apply to home health services. Consolidating repetitive services into a single monthly claim reduces CMS processing costs for relatively small claims and in instances

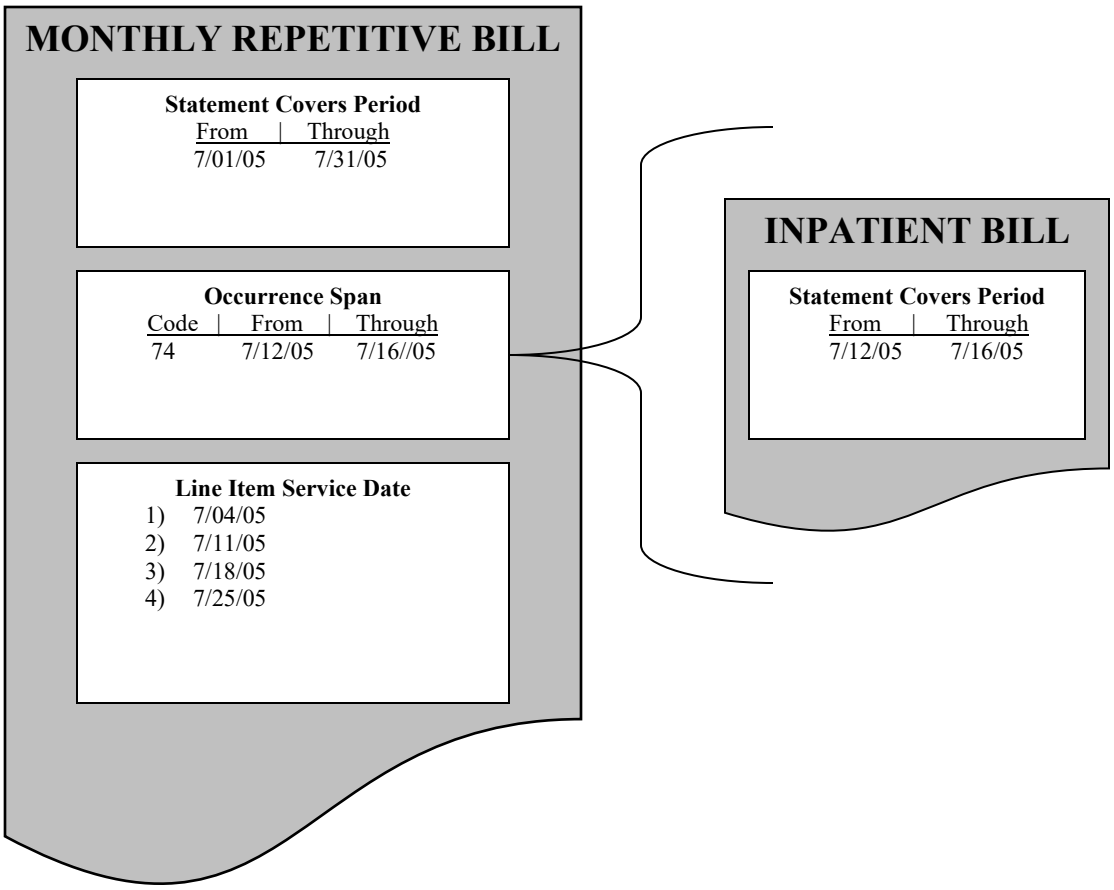
where bills are held for monthly review. Services repeated over a span of time and billed with the following revenue codes are defined as repetitive services:

Type of Service	**Revenue Code(s)**
DME Rental	0290 – 0299
Respiratory Therapy	0410, 0412, 0419
Physical Therapy	0420 – 0429
Occupational Therapy	0430 – 0439
Speech-Language Pathology	0440 – 0449
Skilled Nursing	0550 – 0559
Kidney Dialysis Treatments	0820 – 0859
Cardiac Rehabilitation Services	0482, 0943
Pulmonary Rehabilitation Services	0948

Hospitals in Maryland that are under the jurisdiction of the Health Services Cost Review Commission are subject to monthly billing cycles.

Where there is an inpatient stay, or outpatient surgery, or outpatient hospital services subject to OPPS, during a period of repetitive outpatient services, one bill for repetitive services shall nonetheless be submitted for the entire month as long as the provider uses an occurrence span code 74 on the monthly repetitive bill to encompass the inpatient stay, day of outpatient surgery, or outpatient hospital services subject to OPPS. CWF and shared systems must read occurrence span 74 and recognize the beneficiary cannot receive non-repetitive services while receiving repetitive services, and consequently, is on leave of absence from the repetitive services. This permits submitting a single, monthly bill for repetitive services and simplifies Contractor review of these bills. The following is an illustration explaining this scenario:

Leave of Absence "Carve-Out" Example

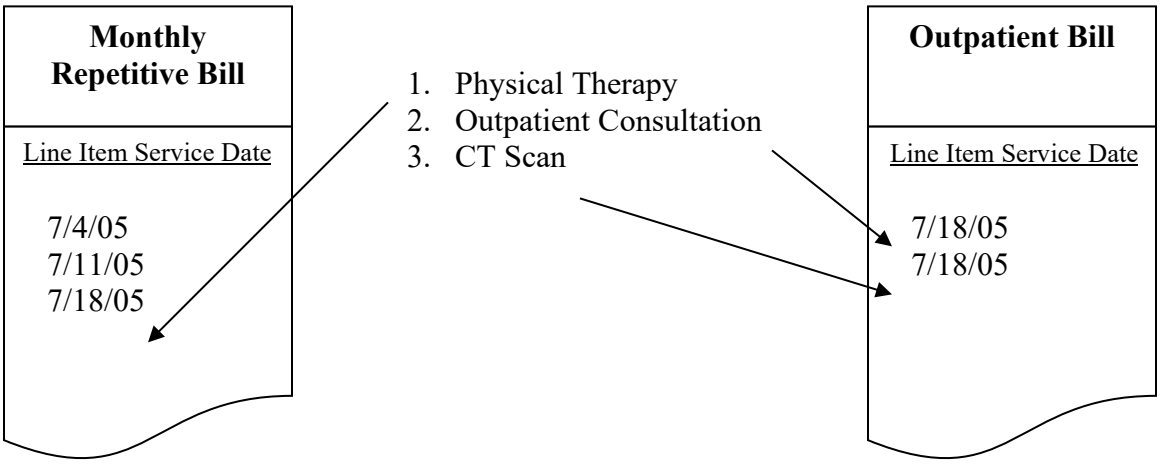


Any items and/or services in support of the repetitive service shall be reported on the same claim even if the revenue code(s) reported with those supported services are not on the repetitive revenue code list (**NOTE:** Supporting items and/or services are those in which are needed specifically in the performance of the repetitive service. Examples may include disposable supplies, drugs or equipment used to furnish the repetitive service).

However, to facilitate APC recalibration, do not report unrelated one-time, non-repetitive services that have the same date of service as a repetitive service (even if both the non-repetitive service and the repetitive service are paid under OPPS). If a non-repetitive OPPS service is provided on the same date as a repetitive service, report the non-repetitive OPPS services, along with any packaged and/or services related to the non-repetitive OPPS service, on a separate OPPS claim. For example, if a chemotherapy drug is administered on a day a repetitive service is also rendered, report the chemotherapy drug, its administration, its related supplies, etcetera, on a separate claim from the monthly repetitive services claim. Similarly, as shown below in the illustration, "Example: Monthly Repetitive Billing Procedure," a physical therapy treatment (which is a repetitive service because it is reported under a revenue code on the repetitive service list) is administered on the same day an outpatient consultation and a CT scan are

furnished, report the physical therapy service on the claim with the other physical therapy services provided during the applicable month. Report the visit for the consultation and the CT scan on a separate claim.

Example: Monthly Repetitive Billing Procedure



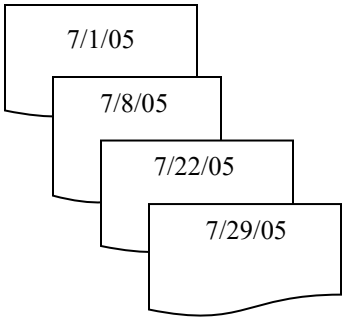
Revenue codes usually reported for chemotherapy and radiation therapy are not on the list of revenue codes that may only be billed monthly. Therefore, hospitals may bill chemotherapy or radiation therapy sessions on separate claims for each date of service. However, because it is common for these services to be furnished in multiple encounters that occur over several weeks or over the course of a month, hospitals have the option of reporting charges for those recurring services on a single bill, as though they were repetitive services. If hospitals elect to report charges for recurring, non-repetitive services (such as chemotherapy or radiation therapy) on a single bill, they must also report all charges for services and supplies associated with the recurring service on the same bill. The services may all be reported on the same claim or billed separately by date of service as illustrated below:

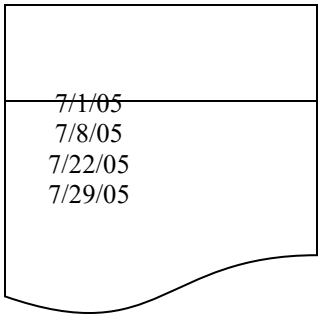
Billing Procedures for Recurring Services Not Defined as Repetitive

1) Submit multiple bills for each date of service (include only the recurring service and its related services):

OR

2) Submit a monthly bill for all line item dates of service (for the entire month's recurring services with all services related to the recurring services):





Indian Health Service Hospitals, Maryland hospitals, as well as hospitals located in Saipan, Guam, American Samoa, and the Virgin Islands are not subject to OPPS. In addition, hospitals that furnish only inpatient Part B services are also exempt from OPPS. Bills for ambulatory surgery in these hospitals shall contain on a single bill all services provided on the same day as the surgery except kidney dialysis services, which are billed on a 72X bill type. Non-ASC services furnished on a day other than the day of surgery shall not be included on the outpatient surgical bill.

See Chapter 16 for clinical diagnostic lab services paid under the fee schedule when included with outpatient bills for other services.

Contractors periodically review bills from providers known to be furnishing repetitive services to determine if they are billing more frequently than proper. Techniques that may be used are:

- Sample review of bills to determine if most are for a monthly period (by using from and thru dates or number of services). This may be done manually or electronically. Contractors may rely on informal communications from their medical review staff, and

Contractors should educate providers that bill improperly. Contractors shall:

- Return bills with an explanation and request proper billing to providers that continue to bill improperly.

- Not return bills where the treatment plan is completed indicating discontinued services because the beneficiary dies or moves.

50.2.3 - Submitting Bills In Sequence for a Continuous Inpatient Stay or Course of Treatment

(Rev. 2578, Issued: 11-01-12, Effective: 01-01-13, Implementation: 04-01-13)

When a patient remains an inpatient of a SNF, TEFRA hospital or unit, swing-bed, or hospice beyond the end of a calendar month, providers must submit a bill for each calendar month. (See §50.2.1 for frequency of billing for inpatient services.) Claims for the beneficiary are to be submitted in service date sequence. The shared system must edit to prevent acceptance of a continuing stay claim or course of treatment claim until the prior bill has been processed. If the prior bill is not in history, the incoming bill will be returned to the provider with the appropriate error message.

When an out-of-sequence claim for a continuous stay or outpatient course of treatment is received, FIs will search the claims history for the prior bill. They do not suspend the out-of-sequence bill for manual review, but perform a history search for an adjudicated claim. For bills other than hospice bills, if the prior bill is not in the finalized claims history, they return to the provider the incoming bill with an error message requesting the prior bill be submitted first, if not already submitted. The returned bill may only be resubmitted after the provider receives notice of the adjudication of the prior bill. A typical error message would be as follows:

Bills for a continuous stay or admission or for a continuous course of treatment must be submitted in the same sequence in which the services are furnished. If you have not already done so, please submit the prior bill. Then, resubmit this bill after you receive the remittance advice for the prior bill.

For a partial hospitalization program claim to determine out-of-sequence claim submission for the outpatient course of treatment, providers must utilize the correct frequency digit in the type of bill as follows:

If the “from” and “through” (FL6) dates on the claim being submitted include the dates for all services of the course of treatment, then the frequency digit in the type of bill will be a “1” [Admit through Discharge Claim] (i.e., 131, 761, or 851). The final Patient Discharge Status code (FL 17) will be entered.

If the “from” and “through” dates (FL6) on the claim being submitted include the dates for services at the start of the course of treatment (first of a series of bills) and additional services are expected to be submitted on a subsequent bill, then the frequency digit in the type of bill will be a “2” [Interim – First Claim] (i.e., 132, 762, or 852). The Patient Discharge Status code (FL 17) will be a “30”.

If the “from” and “through” dates (FL6) on the claim being submitted include the dates for services at the neither at the start or at the completion of the course of treatment and additional services are expected to be submitted on a subsequent bill, then the frequency digit in the type of bill will be a “3” [Interim – Continuing Claim] (i.e., 133, 763, or 853). The Patient Discharge Status code (FL 17) will be a “30”.

If the "from" and "through" dates (FL6) on the claim being submitted include the dates for services at the completion of the course of treatment (last of a series of bills) and no additional services are expected to be submitted on a subsequent bill, then the frequency digit in the type of bill will be a "4" [Interim – Last Claim] (i.e., 134, 764, or 854). The final Patient Discharge Status code (FL 17) will be entered.

Leave of Absence "Carve-Out" process from 50.2.2 applies. Providers may submit Interim Bills daily, weekly, or monthly as long as the claims are submitted with the correct frequency code in the type of bill and sequentially.

For a hospice claim that is out of sequence, the FI searches their claims history. If the FI finds the prior claim has been received but has not been finalized (for instance, it has been suspended for additional development), they do not cause the out of sequence claim to be returned to the provider. Instead, they hold the out of sequence claim until the prior claim has been finalized and then process the out of sequence claim. If the prior hospice claim has not been received, the out of sequence hospice claim is returned to the provider with an error message as described above. FIs shall perform editing to ensure hospice claims are processed in sequence after any necessary medical review of the claims has been completed.

Since hospice claims received out of sequence do not pass all required edits, they do not meet the definition of "clean" claims defined in §80.2 below. As a result, they are not subject to the mandated claims processing timeliness standard and are not subject to interest payments. FIs will enter condition code 64 on the out of sequence claims they are holding when awaiting the processing of the prior claims to indicate that they are not "clean" claims.

50.2.4 - Reprocess Inpatient or Hospice Claims in Sequence
(Rev. 1, 10-01-03)

3-3603.2, definition of spell of illness from MIM 3035
If a beneficiary, provider, or a secondary insurer notifies the FI that out-of-sequence processing increased the liability of the beneficiary or a secondary insurer, the FI confirm this through reviewing claims processed in its history and the Common Working File (CWF) records. If liability is increased, FIs cancel the previously processed bills for that spell-of-illness and reprocess all bills in the spell-of-illness or benefit period in sequence. This may require coordination with another FI where the beneficiary was an inpatient in different hospitals with different FIs or received hospice services from separate hospices with different FIs. The CWF utilization record must be corrected to properly allocate full, coinsurance, and lifetime reserve days, as applicable. The CWF utilization record must also be corrected to reflect the correct hospice periods.

This is an issue only when the beneficiary is an inpatient for more than 30 days (in the same or different facilities) during the spell of illness or benefit period. A spell of illness or benefit period is a period of time (consecutive days) during which covered services

furnished to a patient, up to certain specified maximum amounts, may be paid for by the hospital insurance plan. This situation occurs most often when long-term care hospitals are involved. For hospice claims, out of sequence processed claims must be reprocessed to maintain the integrity of hospice election periods. If an FI is contacted by another FI or any regional office (RO), they cancel all affected claims and reprocess in accordance with the instructions from the lead FI or RO.

The lead FI is the one contacted by a provider, beneficiary, or other insurer complaining of improper payment as result of out-of-sequence billing. The lead FI will coordinate actions with any other FIs involved to cancel and reprocess the bills, as necessary. For inpatient stays, the lead FI verifies that the provider, beneficiary, or other insurer was adversely affected and coordinates these actions directly with any other affected FI to cancel any out-of-sequence bills they processed and posted. For hospice claims, the lead FI verifies an out-of-sequence claim(s) impacted the hospice election period. The lead FI coordinates actions to cancel any bills posted out-of-sequence directly with any other affected FI. All FIs must reprocess all bills based on the actual sequence of the beneficiary's stays at the various providers or on the actual sequence of hospice services. The lead FI controls the sequence in which the bills are processed and posted to CWF.

If the lead FI experiences any difficulty with another FI, they contact their RO to coordinate with any necessary ROs for other affected FIs' bills.

This approach is to be used only when the beneficiary, provider, or other insurer has increased liability as a result of out-of-sequence processing or when the hospice election periods are incorrect. It is not to be used if the liability stays the same, e.g., if deductible is applied on the second stay instead of the first, but there is no issue with regard to the effective date of supplementary coverage.

50.3 - When an Inpatient Admission May Be Changed to Outpatient Status

(Rev. 1760, Issued: 06-23-09; Effective Date: 07-01-09; Implementation Date: 07-06-09)

50.3.1 - Background

(Rev. 2296, Issued: 09-02-11, Effective: 10-01-11, Implementation: 10-03-11)

Payment is made under the hospital Outpatient Prospective Payment System (OPPS) for Medicare Part B services furnished by hospitals subject to the OPPS, and under the applicable other payment methodologies for hospitals not subject to the OPPS. "Outpatient" means a person who has not been admitted as an inpatient but who is registered on the hospital or critical access hospital (CAH) records as an outpatient and receives services (rather than supplies alone) directly from the hospital or CAH.

Under the hospital Condition of Participation (CoP) at 42 C.F.R. §482.12(c), patients are admitted to the hospital or CAH as inpatients only on the recommendation of a physician or licensed practitioner permitted by the State to admit patients to a hospital. In addition,

every Medicare patient must be under the care of a physician or other type of practitioner listed in the regulation ("the practitioner responsible for care of the patient"). In some instances, a practitioner may order a beneficiary to be admitted as an inpatient, but upon reviewing the case, the hospital's utilization review (UR) committee determines that an inpatient level of care is not medically necessary.

Taking this into consideration, CMS obtained a condition code from the National Uniform Billing Committee (NUBC), effective April 1, 2004, that specifies:

Condition Code 44--Inpatient admission changed to outpatient – For use on outpatient claims only, when the physician ordered inpatient services, but upon internal utilization review performed before the claim was originally submitted, the hospital determined that the services did not meet its inpatient criteria.

The utilization review requirements for hospitals and CAH are found in their respective CoPs at §482.30 or §485.641. The hospital must ensure that all the UR activities, including the review of medical necessity of hospital admissions and continued stays required by §482.30(d), are fulfilled as described in the regulation. Section 482.30(d) delineates requirements that hospitals must follow when making the determination as to whether an admission or discharge of a patient is or was medically necessary. Review of admissions may be performed before, at, or after hospital admission. More information about the hospital CoP may be found in Pub.100-07, State Operations Manual, Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals. Section 485.641 requires CAHs to have a similar program for the evaluation of all services they furnish, including the quality and appropriateness of diagnoses and treatments furnished by their staff physician and non-physician practitioners. If in addition to making a medical necessity determination (or evaluating the appropriateness of diagnosis and treatment in a CAH) a hospital or CAH wishes to change a patient's status from inpatient to outpatient, the following requirements apply.
CMS set the policy for the use of Condition Code 44 to address those relatively infrequent occasions, such as a late-night weekend admission when no case manager is on duty to offer guidance, when internal review subsequently determines that an inpatient admission does not meet hospital criteria and that the patient would have been registered as an outpatient under ordinary circumstances. The State Operations Manual states that in no case may a non-physician make a final determination that a patient's stay is not medically necessary or appropriate (see Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals). However, CMS encourages and expects hospitals to employ case management staff to facilitate the application of hospital admission protocols and criteria, to facilitate communication between practitioners and the UR committee or Quality Improvement Organization (QIO), and to assist the UR committee in the decision-making process. Use of Condition Code 44 is not intended to serve as a substitute for adequate staffing of utilization management personnel or for continued education of physicians and hospital staff about each hospital's existing policies and admission protocols. As education and staffing efforts continue to progress, the need for hospitals to correct inappropriate admissions and to report Condition Code 44 should become increasingly rare.

50.3.2 - Policy and Billing Instructions for Condition Code 44

(Rev. 3086, Issued: 10-03-14, Effective: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012, Implementation ICD-10: Upon Implementation of ICD-10; ASC X12: November 4, 2014)

In cases where a hospital or a CAH's UR committee determines that an inpatient admission does not meet the hospital's inpatient criteria, the hospital or CAH may change the beneficiary's status from inpatient to outpatient and submit an outpatient claim (bill type 13x or 85x) for medically necessary Medicare Part B services that were furnished to the beneficiary, provided all of the following conditions are met:

1. The change in patient status from inpatient to outpatient is made prior to discharge or release, while the beneficiary is still a patient of the hospital;

2. The hospital has not submitted a claim to Medicare for the inpatient admission;

3. The practitioner responsible for the care of the patient and the UR committee concur with the decision; and

4. The concurrence of the practitioner responsible for the care of the patient and the UR committee is documented in the patient's medical record.

While typically the full UR committee makes the decision for the committee that a change in patient status under Condition Code 44 is warranted, in accordance with §482.30(d)(1) one physician member of the UR committee may make the decision for the committee, provided he or she is a different person from the concurring practitioner who is responsible for the care of the patient.

When the hospital has determined that it may submit an outpatient claim according to the conditions described above, the entire episode of care should be billed as an outpatient episode of care on a 13x or 85x bill type and outpatient services that were ordered and furnished should be billed as appropriate.

Refer to Pub. 100-04, Medicare Claims Processing Manual; Chapter 30, Financial Liability Protections; Section 20, Limitation On Liability (LOL) Under §1879 Where Medicare Claims Are Disallowed, for information regarding financial liability protections.

When the hospital submits a 13x or 85x bill for services furnished to a beneficiary whose status was changed from inpatient to outpatient, the hospital is required to report Condition Code 44 on the outpatient claim in one of Form Locators 24-30, or in the ASC X12 837 institutional claim format in Loop 2300, HI segment, with qualifier BG, on the outpatient claim. Additional information may be found in Chapter 25 of this manual, (Completing and Processing the Form CMS-1450 Data Set). Condition Code 44 is used by CMS and QIOs to track and monitor these occurrences. The reporting of Condition

Code 44 on a claim does not affect the amount of hospital outpatient payment that would otherwise be made for a hospital outpatient claim that did not require the reporting Condition Code 44.

One of the requirements for the use of Condition Code 44 is concurrence by the practitioner who is responsible for the care of the patient with the determination that an inpatient admission does not meet the hospital's admission criteria and that the patient should have been registered as an outpatient. This prerequisite for use of Condition Code 44 is consistent with the requirements in the CoP in §482.30 (d) of the regulations. This paragraph provides that the practitioner or practitioners responsible for the care of the patient must be consulted and allowed to present their views before the UR committee or QIO makes its determination that an admission is not medically necessary. It may also be appropriate to include the practitioner who admitted the patient if this is a different person than the practitioner responsible for the care of the patient.

If the conditions for use of Condition Code 44 are not met, the hospital may submit a 12x bill type for covered "Part B Only" services that were furnished to the inpatient. Medicare may still make payment for certain Part B services furnished to an inpatient of a hospital when payment cannot be made under Part A because an inpatient admission is determined not to be medically necessary. Information about "Part B Only" services is located in Pub. 100-02, Medicare Benefit Policy Manual, chapter 6, section 10. Examples of such services include, but are not limited to, diagnostic x-ray tests, diagnostic laboratory tests, surgical dressings and splints, prosthetic devices, and certain other services. The Medicare Benefit Policy Manual includes a complete list of the payable "Part B Only" services. See Pub. 100-04, Medicare Claims Processing Manual, chapter 4, section 10.12 for a discussion of the billing and payment rules regarding services furnished within the payment window for outpatient services treated as inpatient services.

Entries in the medical record cannot be expunged or deleted and must be retained in their original form. Therefore, all orders and all entries related to the inpatient admission must be retained in the record in their original form. If a patient's status changes in accordance with the requirements for use of Condition Code 44, the change must be fully documented in the medical record, complete with orders and notes that indicate why the change was made, the care that was furnished to the beneficiary, and the participants in making the decision to change the patient's status.

When Condition Code 44 is appropriately used, the hospital reports on the outpatient bill the services that were ordered and provided to the patient for the entire patient encounter. However, in accordance with the general Medicare requirements for services furnished to beneficiaries and billed to Medicare, even in Condition Code 44 situations, hospitals may not report observation services using HCPCS code G0378 (Hospital observation service, per hour) for observation services furnished during a hospital encounter prior to a physician's order for observation services. Medicare does not permit retroactive orders or the inference of physician orders. Like all hospital outpatient services, observation services must be ordered by a physician. The clock time begins at the time that observation services are initiated in accordance with a physician's order.

While hospitals may not report observation services under HCPCS code G0378 for the time period during the hospital encounter prior to a physician's order for observation services, in Condition Code 44 situations, as for all other hospital outpatient encounters, hospitals may include charges on the outpatient claim for the costs of all hospital resources utilized in the care of the patient during the entire encounter. For example, a beneficiary is admitted as an inpatient and receives 12 hours of monitoring and nursing care, at which point the hospital changes the status of the beneficiary from inpatient to outpatient and the physician orders observation services, with all criteria for billing under Condition Code 44 being met. On the outpatient claim on an uncoded line with revenue code 0762, the hospital could bill for the 12 hours of monitoring and nursing care that were provided prior to the change in status and the physician order for observation services, in addition to billing HCPCS code G0378 for the observation services that followed the change in status and physician order for observation services. For other rules related to billing and payment of observation services, see chapter 4, section 290 of this manual, and Pub.100-02, Medicare Benefit Policy Manual, chapter 6, Section 20.6.

60 – Provider Billing of Non-covered Charges on Institutional Claims

(Rev. 1921, Issued: 02-19-10, Effective: 04-01-10, Implementation: 04-05-10)

60.1 - General Information on Non-covered Charges on Institutional Claims

(Rev. 3086, Issued: 10-03-14, Effective: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012, Implementation ICD-10: Upon Implementation of ICD-10; ASC X12: November 4, 2014)

Charges are tied to items or services described by coding on a line of a claim where they appear together. The institutional claim formats (the ASC X12 837 institutional claim transaction and the Form CMS-1450 paper claim) provide separate fields for the submission of total charges and non-covered charges.

When billing, claims submitters make a choice between submitting charges as covered, or as non-covered. When total charges are submitted and non-covered charges are not submitted, the charges for the claim line are submitted as covered. When a claim line is submitted with covered charges, the provider is seeking payment for that line.

When total charges and non-covered charges submitted on a claim line are equal, the charges for that claim line are submitted as non-covered. When a claim line is submitted with non-covered charges, the provider is not seeking payment for that line and the line is denied payment by Medicare systems. Therefore, Medicare accepts any National Uniform Billing Committee-approved revenue codes when they are submitted with non-covered charges, without regard to whether these revenue codes would be valid for Medicare billing if submitted seeking payment.

Lines submitted with covered and non-covered charges can appear together on a single Medicare claim. In rare instances, covered and non-covered charges can appear on the

same line. In these cases, the total charge amount is greater than the non-covered charge amount on the line.

Even when Medicare payment is not requested, there can be Medicare notice requirements that establish financial liability between beneficiaries and their providers. These liability notices, such as Advance Beneficiary Notices of Noncoverage (ABNs), serve to ensure that providers can shift the financial liability for items and services to their Medicare patients, consistent with §1862(a)(1) and §1879 of the Social Security Act (i.e., the Act). See Chapter 30 of this manual for more information on financial liability and related notices.

> **NOTE:** In this section, the term 'provider' may include institutional providers or suppliers and other comparable entities delivering medical items and services billed on institutional claims.

This statutory ability to shift liability only applies when billing items and services usually covered as part of established Medicare benefits. These benefits are described in law, in Title XVIII of the Act, which authorizes the Medicare Program. Other benefits not addressed in Title XVIII are known as being "statutorily excluded," meaning Medicare is not authorized to pay for them under the Act.

Financial liability for an item or service that could be a Medicare benefit is codified in statute, along with the benefits themselves. Liability occurs when such items or services are thought to be non-covered by the Program for specific reasons also given in the Act:

- §1862(a)(1) on services that otherwise could be covered but which are not medically reasonable and necessary in the individual case at hand,
- §1862(a)(9) for custodial care which Medicare never covers,
- §1879(g)(1) for home care given to a beneficiary who is neither homebound nor needs intermittent skilled services at home, or lastly, under
- §1879(g)(2) for hospice care given to someone not terminally ill.

When one of these stipulated reasons will apply to a denial on an Original Medicare claim, the reason has to appear on a notice given in advance of delivery of services, and before preparation of a related claim. These notices, like an ABN, give a level of detail that allows the involved beneficiary to understand why no coverage is likely to occur in that specific circumstance.

The financial liability that remains when Medicare does not pay belongs to either providers or beneficiaries. Such determinations are made by Medicare when processing related claims. Sometimes, providers and beneficiaries make their own agreements on payment without billing Medicare, which Medicare allows them to do. More often, Medicare is billed, since resulting denials of claims, even when submitted with non-

covered charges, have appeal rights under Medicare over payment. See Chapter 29 of this manual for more information on such appeals.

Appeals rights are not expected to be used for non-covered charges, certainly not with any frequency. When no amounts are in dispute since no payment is sought, appeals tend not to occur. Charges submitted as non-covered should indicate that there is an understanding shared by the involved beneficiary and provider that Medicare payment is not expected. For example, non-covered charges could be used for cosmetic surgery because both parties know this surgery is never a Medicare benefit, or statutorily excluded. The surgery may be billed to Medicare so that subsequent payers could see a Medicare denial when they require proof of denials by payers more primary in the sequence of coverage.

Claims which are rejected by the Medicare contractor or are returned to the provider (or RTP'ed) can be corrected and re-submitted, permitting a payment determination to be made after resubmission. In some cases, beneficiaries may appeal rejections, but they can NEVER appeal RTP'ed claims. Rejections may be apparent on remittances for claims submitted with administrative errors, but beneficiaries cannot be held liable for items and services that were never properly billed to Medicare.

In contrast, denied claims can never be resubmitted, since they are in fact the result of official payment determinations made by Medicare. As mentioned, such determinations can be appealed.

60.1.1 - Basic Payment Liability Conditions

(Rev. 2783, Issued: 09-10-13, Effective: 09-30-13, Implementation: 09-30-13)

With any service delivered, providers must decide which one of the following three conditions apply in order both to properly inform Medicare beneficiaries of their potential liability for payment, and later to bill for this payment. The concepts used in making these decisions are displayed in the following table

TABLE 1:

MEDICARE SCENARIO	Payment 'CONDITION 1'	Payment 'CONDITION 2'	Payment 'CONDITION 3'
DESCRIPTION	Items and services being billed are statutorily excluded from Original Medicare coverage, meaning it is not defined as a specific Medicare benefit defined in the Act;	Items and services being billed are either a reduction or termination of Medicare coverage, or are otherwise expected to be denied, leaving financial liability for a beneficiary or	Items or service is presumed to be a Medicare benefit and can be paid.

	therefore, it is never paid.	provider (see applicable reasons in 60.1 above).	
NOTIFICATION (Prior to billing)	Liability notices are voluntary (i.e., ABN); for statutory exclusions, there are no required Medicare notices.	Liability notices are required (i.e., expedited determination notice, ABN).	Liability notices, mandatory or voluntary, are never used in advance of such billing.
BILLING	Items and services may be billed as non-covered on Medicare claims.	Billing of such items and services can vary, and can depend on the ability to segregate its covered and non-covered portions (if both exist).	Items and services are billed as covered.
LIABILITY (displayed on MSNs or remittances)	Always denied in Medicare claims processing; beneficiaries are liable for these denials unless providers code their claims to transfer liability to themselves.	For any services that are not paid by Medicare itself, properly notified beneficiaries are usually liable for resulting denials.	If Medicare doesn't pay itself as expected, the specific reason for rejection or denial will determine liability according to established Medicare policy.

NOTE: Only one of these conditions can apply to a given item or service, or to a given line of a claim.

To the extent possible in billing Medicare, providers should split claims so that one of these three conditions holds true for all items and services billed on a single claim. Consequently, no more than one type of beneficiary notice on liability would apply to a single claim. This approach should improve understanding of potential liability for all parties and speed processing of the majority of claims.

EXCEPTION: Cases may occur where multiple conditions apply and multiple notices may be necessary:

(A) Claims paid under the outpatient prospective payment system (OPPS); the OPPS requires all services provided on the same day to be billed on the same claim (see §170 of Chapter 4 of this manual), with few exceptions as already given in OPPS instructions (i.e., claims using any of the following 3 condition codes: 21, 20, which are also discussed below in this chapter, and G0);

Or:

(B) Claims using certain claim coding:
- occurrence span codes on inpatient claims,
- modifiers used to differentiate multiple conditions that apply to different lines on the same claim.

These issues are discussed further in subsequent sections of this chapter. More information on each payment condition listed in the table above follows in this section.

Payment Condition 1. There is no required notice if beneficiaries elect to receive services that are excluded from Medicare by statute. This is understood as:

- not being part of a Medicare benefit, or
- not covered for another reason that a provider can define, but that would not relate to potential denials under §§1879 or 1862 (a) of the Act (listed above in 60.1).

If written notification of potential liability for statutory exclusions is desired to aid beneficiaries, even though not required by Medicare, the ABN may be used for such voluntary notification purposes. Explanation of this use can be found at the Centers for Medicare and Medicaid Services (CMS) Web site:

- www.cms.hhs.gov/medicare/bni/; and
- Chapter 30 of this manual, Financial Liability Protections.

Any other situations in which a patient is informed a service is not covered should also be documented in patient records, making clear the specific reason a beneficiary was told a service would be billed as non-covered.

Payment Condition 2. Providers **must** supply a liability notice if payment for services delivered to a Medicare beneficiary are to be reduced or terminated following delivery of the same or similar covered services, **and** those services are thought not to be covered at all specifically for one of the reasons listed under §1862 (a) of the Act. Delivery of such notices can permit a shift of liability under §1879. Providers must give these notices to beneficiaries before services are delivered for which the beneficiary may be liable. Failure to provide such notices when required means a provider will not be able to shift liability to a beneficiary. As a result, the liability must be assumed by the provider. When a mandatory notice is given, patient records should be documented.

Aside from liability requirements of the Act, applicable Conditions of Participation (COPs) MAY also require a provider to inform a beneficiary of payment liability. This must be done BEFORE delivering services not covered by Medicare, IF the provider intends to charge the beneficiary for such services. This is the case with the COPs applicable to home health agencies. In addition to what may be required by the COPs,

providers are advised to respect Medicare beneficiaries' right to information as described in Medicare publications targeted to beneficiaries (e.g. "Medicare and You").

Required Notices for Condition 2. Over time, there have been different types of liability notices, used in different settings for specific types of services:

(1) Notices of Noncoverage have been given to eligible inpatients receiving, or those previously eligible for, non-hospice services covered under Medicare Part A (types of bill (TOB) 11x, 18x, 21x, and 41x) when services at issue no longer met coverage guidelines; for example, when exceeding the number of covered days allowed in a spell of illness for a specific Medicare benefit.

a. In hospitals, these notices have been known as Hospital Issued Notice of Non-coverage (HINNs) or hospital notices of non-coverage (in the past this hospital use was the exclusive use of the term 'notice of non-coverage), and

b. In Skilled Nursing Facilities (SNFs), they may have been known as Sarrassat notices, denial letters or the specific notice called "SNFABN."

Current CMS policy on these benefits, and claims seeking payment for them, can also be found at:

TABLE 2:

BENEFIT	INTERNET ON-LINE MANUAL
Inpatient Hospital	100-02, Benefit Policy, Chapter 1,
"	100-04, Claims Processing, Chapter 3;
SNF. (Part A Paid)	100-02, Benefit Policy, Chapter 8,
"	100-04, Claims Processing, Chapter 6.

- Overall, for these and other Original Medicare benefits, see Chapter 30 of this manual, 100-04, for information on financial liability notices.
- All Medicare manual instructions are accessible at the following Web site:

www.cms.hhs.gov/manuals/

(2) ABNs, when:

(a) Overall medical necessity of a recognized Medicare benefit is in doubt, under §1879 and §1862 (a) of the Act, or

(b) Items and services that were previously covered are to be reduced in payment or terminated, creating financial liability, or

(c) The setting is a hospital or SNF, but their inpatient specific forms are not applicable: ABNs are used for certain outpatient services or services covered under Part B delivered in a SNF or hospital; also, HH not under a plan of care, or

(d) CORF, or

(e) Hospice services, which alone among services discussed here, are paid under Part A.

NOTE: ABNs can refer to a specific notice format but here is used as a general term including notices used for other benefits such as HHABNs, which are used exclusively for home health.

Another form of notice, known as an expedited determination notice, can be simultaneously delivered with Medicare liability notices like ABNs, since both types of notices can be involved in terminations of services. Expedited determination notices are primarily intended to convey information about impending discharge, or termination of services, not liability, which is the focus of notices like ABNs.

Expedited determination notices apply to the following Medicare providers:

- Inpatient Hospital,
- Skilled Nursing Facilities (SNFs),
- Hospices,
- Home Health Agencies, and
- Comprehensive Outpatient Rehabilitation Facilities (CORFs).

These providers are required to give a specific type of notice when all services they are providing, or Medicare payment for those services, terminate. These notices are described at the following locations:

- www.cms.hhs.gov/medicare/bni/; and
- 2005 Transmittal R594CP, which will be placed in Chapter 30 of this manual, Financial Liability Protections, and in the interim is found at:
    - http://www.cms.hhs.gov/Transmittals/ .

Payment Condition 3. This condition occurs when providers are billing for what they believe to be covered services as covered services. There are no notice requirements for this condition, and non-covered charges are not involved when submitting such claims, though denials may result from processing.

Billing follows notification, so providers should remember that in all payment conditions the notices described above would be delivered to the beneficiary before a claim is submitted to Medicare.

The following table summarizes and supplements the information in this subsection:

TABLE 3:

CONDITION	Type of Provider/Type of Bill	Liability Notice
Payment [Liability] Condition 1, No Medicare notice required and liability expected	All providers when service known not to be covered by Medicare	Voluntary notice ONLY, provider expects to receive no Medicare payment.
Payment [Liability] Condition 2, Medicare notice IS required and liability expected	Inpatient only, Part A paid (TOBs: 11x, 18x, 21x, 41x)	Notice of Non-Coverage or comparable form required.
Payment [Liability] Condition 2, Medicare notice IS required and liability expected	Home Health (HH) services under a HH plan of care and paid through the HH prospective payment system (PPS) only (TOBs 32x and 33X)	HHABNs (Form CMS-R-296) required.
Payment [Liability] Condition 2, Medicare notice IS required and liability expected	All providers and services IF, • Hospice • Part B paid services not previously listed above for Condition 2; includes laboratories or providers billing lab tests only (revenue codes 30x, 31x and 92x)	ABN (Form CMS-R-131) required.
Payment [Liability] Condition 3, No Medicare notice required and no liability expected	All providers	No notice requirement, provider expects to receive payment from Medicare.

Providers must decide which payment condition and notice requirement is appropriate to the billing situation in each case. Based on this decision, providers will then apply certain billing instructions are that described in the remainder of this section.

60.1.2 - Billing Services Excluded by Statute
(Rev. 1921, Issued: 02-19-10, Effective: 04-01-10, Implementation: 04-05-10)

The billing instructions in this subsection apply to payment condition 1.
Medicare will not pay for services excluded by statute, meaning that Title XVIII of the SSA either:

- does not describe the items and services in question as all or part of a covered Medicare benefit, or
- describes, but excludes, such items and services from coverage.

Examples of such services are given to beneficiaries in the "Medicare and You" handbook. These services can be billed to Medicare as non-covered on institutional claims.

Items and services excluded by statute cannot necessarily be recognized in specific procedure or diagnosis codes. For example, in some cases, a given code may be covered as part of a given Medicare benefit, but under other cases, when no benefit exists, the same code would not be covered by Medicare. For claims submitted to Medicare contractors, these services that are not Medicare benefits may be:

(A) Not submitted to Medicare at all (see A, immediately below),
(B) Submitted as non-covered line items, or
(C) Submitted on entirely non-covered claims.

A. Medicare does not require procedures excluded by statute to be billed on institutional claims UNLESS:

(1) Established Medicare policy requires either all services in a certain period, covered or non-covered, be billed together so that all such services can be bundled for payment consideration (i.e., procedures provided on the same day to beneficiaries under OPPS), or

(2) Billing is required for reasons other than payment (i.e., when utilization days must be charged in inpatient settings where the benefit itself is limited in duration, such as the 100 day limit of Part A payment for a SNF stay); or

(3) A beneficiary requests Medicare be billed so that the item or service in question will be reviewed by Medicare to make an official payment determination (more on demand billing in §60.3 in this chapter).

B. To submit statutory exclusions as non-covered line items on claims with other covered services, modifiers like –GY can be used on non-covered line items.

C. To submit statutory exclusions on entirely non-covered claims, use condition code 21, a claim-level code, signifying all charges that are submitted on that claim are non-covered charges.

60.1.3 - Claims with Condition Code 21

(Rev. 1921, Issued: 02-19-10, Effective: 04-01-10, Implementation: 04-05-10)

Condition code 21 can be employed to indicate no payment claims are being submitted for other reasons in addition to those mentioned in section 60.1.2. above:

- At a beneficiary's, or other insurer's, request, to obtain a denial from Medicare to facilitate payment by subsequent insurers (ex., statutory exclusions outside Original Medicare benefits, such as most self-administered drugs). This is payment condition 1. These claims are referred to as no-payment claims.

- With an HHABN in special cases (see Chapter 10, §60, of this manual). This is payment condition 2.

General Billing Instructions for No Payment Claims with Condition Code 21 (Other than HH PPS).

No payment claims are sometimes referred to as "billing for denial". They are submitted with condition code 21, which is defined by the National Uniform Billing Committee as "billing for denial notice."

The following instructions for use of condition code 21 are applicable to all bill types, other than HH PPS claims.

- All charges must be submitted as non-covered;
- No modifiers signifying beneficiary or provider liability are necessary;
- Frequency code 0 (zero) must be used in the third position of TOB of the claim, though the frequency codes 7 and 8 may be used when appropriate for provider-submitted claim adjustments/cancellations;
- Total charges must equal the sum of non-covered charges;
- Basic required claim elements must be completed; and
- Statement dates should conform to simultaneous claims for payment, if any.

Non-covered charges billed on these claims, when not rejected, will be denied. Medicare beneficiaries will always be liable for these claims. Such denials can only be overturned on appeal.

If claims do not conform to these requirements, they will be returned to providers for correction and resubmission. However, in the case of claims with statement dates that overlap with other claims, the incoming overlapping claim using condition code 21 will be processed to completion as a rejection, with a unique reason code explaining the reason for the rejection. Providers can then correct and re-submit the claim assuming the overlap in periods was a billing error.

60.1.3.1 – Provider-liable Fully Noncovered Outpatient Claims
(Rev. 1921, Issued: 02-19-10, Effective: 04-01-10, Implementation: 04-05-10)

Originally with the creation of the ability of outpatient institutional providers to submit non-covered charges, only two types of fully non-covered claims were permitted: (1) No payment claims using condition code 21, or (2) Demand bills (see 60.3 below in this chapter).

However, based on input from both Medicare contractors and providers, CMS recognized the need for entirely non-covered claims that were provider-liable. This meant a new billing method was necessary, as no payment claims with condition code 21 are never provider liable, and liability on demand bills cannot be assured until after review/adjudication by Medicare. A primary example of this need is a case in which a provider has failed to provide an ABN when required under payment condition 2, and chooses to accept all liability for services billed as non-covered.

Therefore, entirely non-covered outpatient claims are also allowed when billed with all non-covered charges, as long as either:

(1) There are no indicators of liability on the claim at the claim or line level preventing the shared system from defaulting to hold providers liable on all denied line items; or

(2) All indicators at the claim or line level show provider, not beneficiary, liability.

An example of such an indicator is the -GZ modifier, which is often used in the case where a provider fails to give an ABN. In both cases, these line items, all submitted as non-covered, will be denied as provider liable.

60.2 - Noncovered Charges on Inpatient Bills
(Rev. 1921, Issued: 02-19-10, Effective: 04-01-10, Implementation: 04-05-10)

No Payment Inpatient Hospital and SNF Claims. Where stays begin with a non-covered level of care and end with a covered level (within the same month for SNF billing), only one claim is required for both the non-covered and covered period, which must be billed in keeping with other billing frequency guidance (i.e., SNFs are required to bill monthly). However, SNFs and inpatient hospitals are required to submit discharge bills in cases of no payment. These bills must correctly reflect provider and beneficiary liability (see Chapter 6, §40.6.4 of this manual)

For inpatient hospital PPS claims that cannot be split into covered and non-covered periods, hospital providers can submit occurrence span code 77 to represent provider-liable non-covered periods, and occurrence span code 76 for beneficiary-liable non-covered periods.

These procedures must be followed for Part A inpatient services (TOBs: 11x (hospital), 18x (swing bed), 21x (SNF), 41x (religious non-medical health care institutions—RNHCI)), but the list that follows is not required for inpatient Part B claims:

- All charges submitted as non-covered;
- Frequency code 0 (zero) must be used in the third position of the type of bill (TOB) form locator of the original claim (i.e., not adjustment or cancellation)

NOTE: If providers do not submit no payment claims with this frequency code, the shared systems may already act to change the frequency code to 0 or return the claim to the provider.

- Total charges must equal the sum of non-covered charges;
- Basic required claim elements must be completed;

NOTE: Units are not required when reporting non-covered days on SNF claims or Inpatient Rehabilitation claims.

Claims that do not conform to these requirements will be returned to providers. For SNFs, occurrence code 22 should also be used on benefits exhaust claims when SNF care is reduced to a non-covered level and benefits had previously been exhausted (see Chapter 6, section 40.7 in this manual).

Current instructions for inpatient no payment claims are found in the following locations:

TABLE 4:

BENEFIT	INTERNET ON-LINE MANUAL
Inpatient Hospital	100-02, Benefit Policy, Chapter 1
"	100-04, Claims Processing, Chapter 3, §40.4, Chapter 3 (Inpatient Hospital) on no payment claims
SNF (Paid from Part A)	100-02, Benefit Policy, Chapter 8
"	100-04, Claims Processing, Chapter 6, §40.8, Chapter 6 (Inpatient SNF) on no payment claims

60.2.1 – Billing for Non-covered Procedures in an Inpatient Stay

(Rev. 1895, Issued: 01-15-10, Effective: 04-01-10, Implementation: 04-05-10)

As described in Section 1862 of the Social Security Act, providers are not to seek reimbursement for non-covered services/items. However, when a non-covered procedure is provided during an inpatient stay where a covered procedure is also performed, the claims processing system is unable to decipher what procedure code(s) is/are non-covered, so as to not consider such procedure(s) for payment (more specifically, to ignore non-covered procedures when grouping to the MS-DRG). Therefore, effective for inpatient discharges April 1, 2010, hospitals must only seek payment for covered services by removing non-covered procedure codes and related charges from the payable Type of Bill (TOB) 11X.

If a hospital wishes to bill non-covered procedure(s) and related non-covered charges for whatever reason (e.g., a Medicare denial), the hospital may submit such services/charges on a TOB 110 (no-pay claim). The non-covered claim must be billed with the same Statement Covers Period (From and Through date) as the payable TOB 11X submitted for the same stay.

60.3 – Noncovered Charges on Institutional Demand Bills
(Rev. 332, Issued: 10-22-04, Effective: 04-01-05, Implementation: 04-04-05)

60.3.1 - Background on Institutional Demand Bills (Condition Code 20)
(Rev. 1921, Issued: 02-19-10, Effective: 04-01-10, Implementation: 04-05-10)

Demand bills are both a principle and a mechanism of Medicare. The principle goes back to the founding of the Program, reflected in the protection of the rights of the Program's beneficiaries being among the first sections of Title XVIII. The principle assures that beneficiaries have the right to demand that Medicare be billed for the services provided to them, whether or not that billing provides Medicare payment. By assuring claims are sent to and processed by Medicare, permitting official payment decisions to be made, beneficiaries retain the right to appeal payment decisions made on those claims, when they believe need to use that right exists.

The mechanism of demand billing is the process by which providers submit claims that beneficiaries have requested be sent to Medicare. Specific procedures were developed over time to accomplish such billing, and these procedures also became known as demand billing.

A. Demand Billing Procedures

"Traditional demand bills" is a term used to encompass the only administrative billing option that existed for demand bills before the ABN was used. These bills used condition code 20 to indicate a beneficiary has requested billing for a service, even though the provider of the service may have advised the beneficiary that Medicare was not likely to pay for this service. That is, there was some dispute as to whether a service was covered or not, leading for a need for Medicare to review the claim and make a formal payment decision. If there was no dispute, billing a no payment claim or other options for non-covered charges would be more efficient and appropriate.

In the past, traditional demand billing was not always consistent or used by all providers. There was no uniform notice requirement across Medicare benefits. Such instructions as existed required 100 percent of specific types of demand bills to be suspended for manual review (inpatient SNF/home health, TOBs 21x, 32x, 33x), and required the provider to submit additional documentation for development to determine the medical justification for the service(s) in question.

B. Advent of Liability Notices for Outpatient Benefits

This changed once liability notices related to outpatient benefits, ABNs, were created. If an ABN was given, special billing requirements applied, and traditional demand billing was NOT used. Now, only in cases when the ABN is NOT given, services for which coverage is questioned are submitted as non-covered using traditional demand billing. This traditional demand billing process is now open to all provider types, inpatient and outpatient.

Even though there are no notice requirements with traditional demand bills, providers are always encouraged to advise beneficiaries when they may be liable for payment before delivering such services, and may be required to do so by applicable COPs. In such cases, providers should also document their records that such advice has been given.

Demand billing is resource intensive for the Medicare program, and affects the timeliness of payment determinations, which should prevent conscientious providers from abusing this mechanism when there is no true doubt as to coverage/payment. Routine billing of covered services and billing of non-covered charges should both be used as appropriate when coverage/payment is not believed to be in doubt instead of demand billing. Liability notices are not needed if a triggering event requiring their delivery, such as those for an ABN, does not occur. Beneficiaries retain appeal rights when these other billing mechanisms are used, even though no liability notice is delivered.

60.3.2 - Inpatient and Outpatient Demand Billing Instructions
(Rev. 1921, Issued: 02-19-10, Effective: 04-01-10, Implementation: 04-05-10)

A. Scope of this Subsection

The instructions in this subsection apply to demand bills other than for HH PPS and apply with some modification for Part A SNF services. Demand bills for those services are subject to special instructions that are cited below.

1. HH PPS Demand Bills. There are special instructions for HH PPS demand bills. Such special instructions must be followed if:

(a) An HHABN is required, or

(b) If a beneficiary requests demand billing when receiving care from a home health agency (HHA) in an HH PPS episode. Instructions for such bills can be found at:

- §50 of Chapter 10 (Home Health) of the Medicare Claims Processing Manual; and
- Note these HH PPS demand bills use frequency code 9.

2. SNF Demand Bills. There are special instructions relating to collection of funds from patients for inpatient Part A SNF demand bills, which can be found in Chapter 30, §70 of the Medicare Claims Processing Manual. In all other respects, the instructions below apply to SNF Part A services also.

B. General Instructions

Inpatient and outpatient providers are required to submit demand bills using condition code 20 when requested by beneficiaries. Billing with condition code 20 is ONLY in case when an ABN is not given/not appropriate for billing related to doubtful liability (for ABN instructions, see §60.4.1 below). Medicare contractors perform review of demand bills with condition code 20, to assure compliance with codified Medicare medical necessity, coverage and payment liability policy.

Other covered services may appear on demand bills, but not other non-covered charges, as all non-covered charges on demand bills will be considered in dispute and in need of review. Allowing covered and non-covered services to come in on demand bills will allow all services provided in the statement covers period to be billed simultaneously, though payment of the covered services will be delayed by the review and development of the non-covered charges when not split to a separate claim. For this reason, providers should break out demand billed services to separate claims for discrete time periods with all non-covered charges whenever possible. Demand bills must contain at least one non-covered charge, the coverage of which is at issue, when the Medicare contractor receives them from the provider, or claims with condition code 20 will be returned to the provider.

No payment bills using condition code 21 are only used for services that are not in dispute, as opposed to non-covered charges on demand bills. Therefore, Condition Code 21 claims can be simultaneously submitted with such bills.

No claims seeking payment and submitted with all covered charges may be submitted by the same provider simultaneously with a demand bill for the same beneficiary. This restriction is required because some services on demand bills may be found covered upon review. If such overlapping claims with covered services are received, the incoming claim will be processed to completion as a rejection, with a unique reason code explaining the reason for the rejection. Providers can then correct and re-submit the claim assuming the overlap in periods was a billing error.

Providers should be aware CMS may require development of any non-covered charge on traditional demand bills. Such services will then be paid, RTP'ed, rejected or denied in accordance with other instructions/edits applied in processing to completion.

C. Final Summary

In summary, other general requirements for demand bills are:

- Condition Code 20 must be used;
- All charges associated with Condition Code 20 must be submitted as non-covered;
- All non-covered services on the demand bill must be in dispute;
- At least one non-covered line must appear on the claim related to the services in dispute;
- Unrelated covered charges are allowed on the same claim;
- Unrelated non-covered charges not in dispute, if any, would be billed on a no payment claim using Condition Code 21;
- Frequency code zero should be used if all services on the claim are non-covered;
- Occurrence code 32 (i.e., ABN) is NEVER submitted on a claim using condition code 20; and
- Basic required claim elements must be completed.

Claims not meeting these requirements will be returned to providers.

60.4 - Noncovered Charges on Outpatient Bills

(Rev. 2694, Issued: 05-03-13, Effective: 10-01-13, Implementation: 10-07-13)

The term "outpatient" is often used very generally. In this section, the term "outpatient" uses the designation of types of bill as inpatient or outpatient as defined in the National Uniform Billing Committee.

TABLE: Original Medicare Types of Bill – Inpatient or Outpatient.

Designation	Types of Bill Paid by Original Medicare	Medicare Trust Fund Payment
Inpatient	11x – Hospital 18x – Swing Bed 21x – Skilled Nursing Facility (SNF) 41x – RNHCI – Religious Non-Medical Health Care Institution	Part A
Outpatient	81x, 82x – Hospice	Part A
	32x, – Home Health (HH) Services under a Plan of Treatment	Part A and Part B

	12x, 13x, 14x – Hospital 22x, 23x – SNF 34x – HH Services not under a Plan of Treatment 71x – RHC – Rural Health Clinic 72x – RDF – Renal Dialysis Facility 74x – OPT – Outpatient Physical Therapy (Rehabilitation Agency) 75x – CORF – Comprehensive Outpatient Rehabilitation Facility 76x – CMHC – Community Mental Health Center 77x – FQHC – Federally Qualified Health Center 85x – Critical Access Hospital (CAH)	Part B

Note that under these designations, types of bill 12X and 22X which are referred to as "inpatient Part B," are designated as outpatient. Also, hospice claims are designated as outpatient while they can report both inpatient and outpatient levels of care.

60.4.1 - Outpatient Billing with an ABN (Occurrence Code 32)

(Rev. 1921, Issued: 02-19-10, Effective: 04-01-10, Implementation: 04-05-10)

The billing instructions in this subsection apply to payment condition 2.

If an ABN is given, the billing procedures in this subsection must be used, rather than traditional demand billing. Using an ABN is frequently required, and is also allowed on a voluntarily basis when a provider sees fit. It is used more often than traditional demand billing.

Claim level coding

When a provider determines the beneficiary's services for certain benefits should be terminated, the provider must follow the ED instruction requirements located at section 150.3 below. If the beneficiary chooses to receive non-covered services after the date the provider believes covered services are terminated, the provider must also issue an ABN to the beneficiary.

In using the ABN, beneficiaries select only one option on the ABN notice prior to billing, after they have been told that the provider anticipates Medicare will not cover a service. Claims, other than HHPPS claims, billed in association with an ABN never use condition code 20 or 21, and will be returned to providers if received with those codes. Instead, the claims:

- Must use occurrence code 32 to signify all services on the claim are associated with one particular ABN given on a specific date, unless the use of modifiers makes clear that not every line on the claim is linked to the ABN;

- Must provide the date the ABN was signed by the beneficiary in association with the occurrence code;

- Must use occurrence code 32 and the accompanying date multiple times if more than one ABN is tied to a single claim for services that must be bundled/billed on the same claim;

- Must submit all ABN-related services as covered charges (note –GA modifier exception, below); and

- Must complete all the same basic required claim elements as comparable claims for covered services.

Providers should be aware CMS may require suspension of any claims using occurrence code 32 for medical review of covered charges associated with an ABN.

If claims using occurrence code 32 remain covered, they will be paid, RTP'ed, rejected or denied in accordance with other instructions/edits applied in processing. Denials made through automated medical review of service submitted as covered are still permitted after medical review, and the Medicare contractor will determine if additional documentation requests or manual development of these services are warranted. For all denials of services associated with the ABN, the beneficiary will be liable.

Line level coding

The –GA modifier is used when provider must bill some services which are related and some which are not related to a ABN on the same claim. The –GA modifier is used when both covered and non-covered service appear on an ABN-related claim. Occurrence code 32 must still be used on claims using the –GA modifier, so that these services can be linked to specific ABN(s). In such cases, only the line items using the –GA modifier are considered related to the ABN and must be covered charges, other line items on the same claims may appear as covered or non-covered charges.

60.4.2 - Line-Item Modifiers Related to Reporting of Non-covered Charges When Covered and Non-covered Services Are on the Same Outpatient Claim

(Rev. 2783, Issued: 09-10-13, Effective: 09-30-13, Implementation: 09-30-13)

Several Healthcare Common Procedural Coding System (HCPCS) modifiers are used to signify a specific line item is either not covered or not payable by Medicare, for many different reasons. The chart immediately below lists those modifiers, many more commonly used on professional claims, for services not covered or not payable by

Medicare. Modifiers not payable on professional claims are also not payable on institutional claims and will be denied if submitted on such claims. Providers are liable for these denials, UNLESS a specific modifier (see second table in this section) or indicator on the claim (i.e., occurrence code 32) specifically assigns liability to the beneficiary.

NOTE: This table does not include ambulance origin and destination modifiers, which may fall into the ranges of modifiers values below, but are NOT non-covered by definition.

Source of the Modifier List	**Non-covered Modifiers**	**Claims Processing Instructions**	**Definition Source**
HCPCS Modifiers Not Covered or Not Payable by Medicare by HCPCS Definition (HCPCS Administrative Instruction)	-A1 through -A9, -GY, -GZ, -H9, -HA through -HZ, -SA through -SE, -SH, -SJ, -SK, -SL, -ST, -SU, -SV, -SY, -TD through -TR, -TT through -TW, -U1 through -U9, -UA through –UD, –UF through -UK	Institutional standard systems will deny all line items on all TOBs using these modifiers in all cases as part of processing claims; provider liability is assumed EXCEPT when noted as beneficiary liable in accordance with the chart below (of the total set to the left:-GY)	Use as defined by publication of HCPCS codes by CMS
CPT/HCPCS Modifiers Permitted on OPPS Claims	See current OPPS instructions	Institutional standard systems accept these modifiers for processing on OPPS claims (TOBs: 12x, 13x, 14x) in accordance with HCPCS/CPT definitions	CPT numerical modifiers defined in publication of "CPT Manual" by the American Medical Association; HCPCS codes as defined by publication of HCPCS codes by CMS
Modifiers Used in Billing Ambulance Non-covered Charges	-GY, -QL, -QM* or -QN*, -TQ, alpha origin/destination modifiers*	Applicable TOBs for ambulance billing: 12x, 13x, 22x, 23x, 83x, 85x	See ambulance instructions and chart immediately below
Specific HCPCS Modifiers to Consider Related to Non-covered Charges or ABNs	-EY, -GA, -GK, -GL, -GY, -GZ, -KB,	Institutional standard systems accept some of these modifiers for processing as specified on the chart below	See chart immediately below

* These modifiers are not non-covered by definition, but rather are commonly used on non-covered lines

In the past, modifiers were more frequently used to qualify procedure codes submitted on professional billing formats. Use of modifiers has increased in institutional billing over

time, though institutional claims do not always require the use of procedure codes in addition to revenue codes.

Institutional shared systems require procedure codes to be present any time a modifier is used, whether the line is covered or not. Providers should use explicit procedure or HCPCS coding to describe services and items they deliver, even when submitting these items as non-covered. In cases in which providers need to submit a non-covered service for which Medicare institutional claims have not required HCPCS coding in the past, such as with drugs or supplies, the following HCPCS code can be used with the appropriate revenue code in order to employ a modifier:

A9270 Non-covered item or service

Institutional shared systems will accept this code and it will be denied in all cases, since it is non-covered by Medicare by definition. Liability will rest with the provider, unless a modifier is used to assign liability to the beneficiary (i.e., -GL, -GY), when the beneficiary has been informed, prior to service delivery, that he/she may be liable for payment. Note –GA or –KB modifiers cannot be used with this code since they require covered charges. Modifiers most likely to be used with ABNs or non-covered charges or liability notices are listed below.

Table: Definition of Modifiers Related to Non-covered Charges/ABNs for Institutional Billing

Modifier	**HCPCS Modifier Definition**	**HCPCS Coverage/ Payment/ Administrative Instruction**	**Notice Requirement/ Liability**	**Billing Use**	**Payment Result**
EY	No Physician or Other Licensed Health Care Provider Order for this Item or Service	None	None, cannot be used when HHABN or ABN is required, recommend documenting records; liability is provider unless other modifiers are used (-GL or -GY)	To signify a line-item should not receive payment when Medicare requires orders to support delivery of a item or service (i.e., TOBs 21x, 22x, 32x, 33x, 34x, 74x, 75x, 76x, 81x, 82x, 85x)	When orders required, line item is submitted as non-covered and services will be denied

Modifier	HCPCS Modifier Definition	HCPCS Coverage/ Payment/ Administrative Instruction	Notice Requirement/ Liability	Billing Use	Payment Result
GA	Waiver of Liability Statement Issued, as Required by Payer Policy	None	ABN required; beneficiary liable	To signify a line item is linked to the mandatory use of an ABN when charges both related to and not related to an ABN must be submitted on the same claim	Line item must be submitted as covered; Medicare makes a determination for payment
GK	Reasonable and Necessary Item/Service Associated with a –GA or –GZ modifier	None	ABN required if –GA is used; no liability assumption since this modifier should not be used on institutional claims	Not used on institutional claims. Use –GA or –GZ modifier as appropriate instead	Institutional claims submitted using this modifier are returned to the provider
GL	Medically Unnecessary Upgrade Provided instead of Non-Upgraded Item, No Charge, No ABN	None	Can't be used if ABN/HHABN is required, COPs may require notice, recommend documenting records; beneficiary liable	Use only with durable medical equipment (DME) items billed on home health claims (TOBs: 32x, 33x, 34x)	Lines submitted as non-covered and will be denied
GY	Item or Service Statutorily Excluded or Does Not Meet the Definition of Any Medicare Benefit	Non-covered by Medicare Statute (ex., service not part of recognized Medicare benefit)	Optional notice only, unless required by COPs; beneficiary liable	Use on all types of line items on provider claims. May be used in association with modifier –GX.	Lines submitted as non-covered and will be denied

Modifier	HCPCS Modifier Definition	HCPCS Coverage/ Payment/ Administrative Instruction	Notice Requirement/ Liability	Billing Use	Payment Result
GZ	Item or Service Expected to Be Denied as Not Reasonable and Necessary	May be non-covered by Medicare	Cannot be used when ABN or HHABN is actually given, recommend documenting records; provider liable	Available for optional use on demand bills NOT related to an ABN by providers who want to acknowledge they didn't provided an ABN for a specific line	Lines submitted as non-covered and will be denied
KB	Beneficiary Requested Upgrade for ABN, more than 4 Modifiers on a Claim	None	ABN Required; if service denied in development, beneficiary assumed liable	Use only on line items requiring more than [2 or] 4* modifiers on home health DME claims (TOBs 32x, 33x, 34x)	Line item submitted as covered, claim must suspend for development
QL	Patient pronounced dead after ambulance called	None	None, recommend documenting records; provider liable	Use only for ambulance services (TOBs: 12x, 13x, 22x, 23x, 83x, 85x)	Mileage lines submitted as non-covered and will be denied; base rate line submitted covered
TQ	Basic life support transport by a volunteer ambulance provider	Not payable by Medicare	None, recommend documenting records; provider liable	Use only for ambulance services (TOBs: 12x, 13x, 22x, 23x, 83x, 85x)	Lines submitted as non-covered and will be denied
GX	Notice of Liability Issued, Voluntary Under Payer Policy	None	Used when a provider issued an ABN on a voluntary basis; beneficiary liable	Use on all types of provider claims when a voluntary notice has been issued. May be used in association with modifiers –GY or used separately.	Lines submitted as non-covered and will be denied

* **NOTE**: Many provider systems will not allow the submission of more than two modifiers. In such cases, despite the official definition and the capacity of the Medicare systems to take in five modifiers on a line with direct EDI submission, contractors processing home health claims should educate that it is appropriate to use this modifier when three modifiers are needed if there is a two-modifier limit.

All modifiers listed in the chart immediately above need to be used only when non-covered services cannot be split to entirely non-covered claims. Modifiers indicating provider liability cannot be used on entirely no payment claims for which the beneficiary has liability. Inappropriate use of these modifiers may result in entire claims being returned to providers.

60.4.3 – Liability Considerations for Bundled Services

(Rev. 2783, Issued: 09-10-13, Effective: 09-30-13, Implementation: 09-30-13)

Some Medicare payment policies, for outpatient services, group or bundle several items or services into a single unit for payment. Questions arise in such cases, in terms of notifying beneficiaries of liability and billing, when some of the services in the bundle are thought to be covered, and some are not.

Chapter 30 of this manual states in several sections that ABNs may not be used to shift liability to a beneficiary in the case of services or items for which full payment is bundled into other payments; that is, where the beneficiary would otherwise not be liable for payment for the service or item because bundled payment is made by Medicare. Using an ABN to collect a charge for an individual items or service from a beneficiary where full payment is made for that and other care on a bundled basis constitutes double billing.

As a result of this policy, an ABN has to apply to all of a bundled service, or none of it. This means all of a bundled service must be billed as noncovered, or none of it. Therefore, as long as part of a bundled service is certain to be covered or medically necessary, billing the entire bundled service as covered is appropriate. Medicare adjudication may still result in all, part or none of such services being paid, or something submitted as one type of bundled payment being re-grouped into another type of payment.

If the entire bundle is certain to be non-covered, the service should be billed as noncovered. If there is overall doubt as to the medical necessity of the bundle, such as when a Medicare benefit does not seem to be medically necessary, then the instructions for billing in association with an ABN or for demand billing would apply. This is always true when necessity is in doubt relative to all services in the bundle, but may also be used if a provider is uncertain of necessity of the majority services, or if there is discomfort in billing the entire bundle as covered for a specific reason.

60.5- Coding That Results from Processing Noncovered Charges

(Rev. 3510, Issued: 04-29-16, Effective: 10-01-16, Implementation; 10-03-16)

Codes Returned to Providers and Beneficiaries

After processing is complete, remittance advice notices are used to explain to providers the difference between the charges they submitted for payment and what Medicare paid on their claim. The Medicare Summary Notice, or MSN, is used at the same time to inform beneficiaries about any payments made on their behalf.

Liability for noncovered charges is communicated using the Group Code on the remittance advice. When the beneficiary is liable, contractors use Group Code PR. When the provider is liable, contractors use Group Code CO.

Contractors shall deny services that are submitted with modifier GZ.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: CO
CARC: 50
RARC: N/A
MSN: 8.81

Contractors shall deny services that are submitted with modifier GY.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: PR
CARC: 96
RARC: N425
MSN: 16.10

Codes Used by Medicare Contractors

Medicare contractors use nonpayment codes when transmitting institutional claims to CWF in cases where payment is not made. Claims where partial payment is made do not require nonpayment codes.

Both the shared system for institutional claims and CWF react to CMS-created non-payment codes on entirely noncovered claims. The standard system must enter the appropriate code in the "Non-payment Code" field of the CWF record if the non-payment situation applies to all services present on the claim. It does not enter the nonpayment code when either partial payment is made, or payment is made in full by an insurer primary to Medicare. These codes alert CWF to bypass edits in processing that are not

appropriate in nonpayment cases. Nonpayment codes also alert CWF to update a beneficiary's utilization records (deductible, spell of illness, etc.) in certain situations. Nonpayment codes themselves do not assign liability to provider or beneficiary on Medicare claims.

Medicare contractors and systems use the following nonpayment codes:

Code	Contractor Uses	Effect on Processing
B	Placed on Part B-paid inpatient claims when prior to claim 'From' date either: • Benefit and/or lifetime reserve days are exhausted; • Full day or coinsurance days are exhausted; • Beneficiaries elected not to use lifetime reserve days.	• Charges are processed as noncovered; • utilization not chargeable; • cost report days not applied.
R	Placed on claims when: • SNF inpatient services are denied for reasons other than lack of medical necessity or care being custodial in nature; • Provider failed to file claims within timely filing limits; • Beneficiary refused to request benefit on a claim.	• Charges are processed as noncovered and there is no payment; • utilization is chargeable and some charges may go to CWF as covered to update utilization correctly; • cost report days not applied.
N	Placed on claims when the provider is liable and: • The provider knew, or should have known, Medicare Part A or B would not pay; • Care billed was not paid by Medicare because either custodial or not reasonable or necessary; • Provider failed to submit requested documentation.	• Charges are processed as noncovered; • utilization not chargeable; • cost report days are applied.
N	Placed on claims when the beneficiary is liable and:	• Charges are shown as noncovered ;

Code	Contractor Uses	Effect on Processing
	• Statutory exclusions (e.g., most dental care and cosmetic surgery that Medicare never covers); • Claims not filed within timely filing limits BUT provider not at fault; • Medicare decision find the beneficiary 'at fault' under limitation of liability • Inpatient psychiatric reduction applies because days are used in advance of admission (see IOM Pub. 100-02, Chapter 4); • All services provided after date active care in psychiatric hospital ended; • Inpatient hospital or SNF benefit provided after date covered care ended; • MSP cost avoidance denials (see IOM Pub. 100-05).	• neither utilization nor cost report days are reported.
No code entered	Despite no payment, no code is entered because: • Deductible/coinsurance exceeds the payment amount; • Other payer paid for all Medicare covered care such as: EGHP; LGHP; auto, no-fault, WC or other liability insurance (including BL); NIH, PHS, VA or other governmental entity or liability insurance; • Care was provided to a MA (Medicare Part C) enrollee when that part of Medicare, not Original Medicare, has jurisdiction for payment.	

Other than the distinct codes used for Medicare Secondary Payer (MSP) cost-avoided claims, entirely noncovered outpatient claims use either an "N" or "R" nonpayment code. Generally, the R code should be used instead of the N code in all cases where a spell of illness must be updated.

The HH spell of illness must be updated when processing noncovered HH PPS claims in certain situations. Accordingly, the shared systems must update home health value codes 62-65 when the R code is used, filling the values associated with the codes as zeros, since

these value codes are needed to effectuate information related to the A-B Shift in the home health spell. CWF consistency edits related to the R nonpayment code will be bypassed in these cases. The CWF will update the dates of earliest and latest billing activity (DOEBA and DOLBA) for the benefit period, but not for the episode

70 - Time Limitations for Filing Part A and Part B Claims
(Rev. 2140, Issued: 01-21-11, Effective: 01-01-10, Implementation: 02-22-11)

Medicare regulations at 42 CFR 424.44 define the timely filing period for Medicare fee for service claims. In general, such claims must be filed to the appropriate Medicare claims processing contractor no later than 12 months, or 1 calendar year, after the date the services were furnished. (See section §70.7 below for details of the exceptions to the 12 month timely filing limit.)

70.1 - Determining Start Date of Timely Filing Period -- Date of Service
(Rev. 2140, Issued: 01-21-11, Effective: 01-01-10, Implementation: 02-22-11)

In general, the start date for determining the 12 month timely filing period is the date of service or "From" date on the claim. For institutional claims (Form CMS-1450, the UB-04 and now the 837 I or its paper equivalent) that include span dates of service (i.e., a "From" and "Through" date span on the claim), the "Through" date on the claim is used for determining the date of service for claims filing timeliness. Certain claims for services require the reporting of a line item date of service. For professional claims (Form CMS-1500 and 837-P) submitted by physicians and other suppliers that include span dates of service, the line item "From" date is used for determining the date of service for claims filing timeliness. (This includes DME supplies and rental items.) If a line item "From" date is not timely but the "To" date is timely, contractors must split the line item and deny the untimely services as not timely filed. Claims having a date of service on February 29 must be filed by February 28 of the following year to be considered timely filed. What constitutes a claim is defined below.

70.2 - Definition of a Claim for Payment
(Rev. 2140, Issued: 01-21-11, Effective: 01-01-10, Implementation: 02-22-11)

Medicare regulations at 42 CFR 424.5 describe basic conditions for Medicare payment. These regulations at paragraphs (5) and (6) define a claim for payment as a request for payment from a provider, supplier, or beneficiary, and the provider, supplier, or beneficiary requesting payment must furnish the appropriate Medicare contractor with sufficient information to determine the amount of payment. Institutional claims are in all cases filings by the provider and issues of assigned or non-assigned claims do not apply.

Medicare regulations at 42 CFR 424.32 describe the basic requirements for all claims. Specifically, 42 CFR 424.32 (a) (1) states, "A claim must be filed with the appropriate intermediary or carrier on a form prescribed by CMS in accordance with CMS instructions." Therefore, this regulation sets out three distinct conditions that must be satisfied in order for a provider submission to be considered a claim

- it must be filed with the appropriate Medicare contractor,
- it must be filed on the prescribed form and
- it must be filed in accordance with all pertinent CMS instructions. The sections below define each of these conditions in greater detail.

70.2.1 - Appropriate Medicare Contractor

(Rev. 2140, Issued: 01-21-11, Effective: 01-01-10, Implementation: 02-22-11)

Submissions for services must be filed with the appropriate Medicare contractor. It is the provider's or supplier's responsibility to submit each claim to the appropriate contractor. Medicare contractors may attempt to re-route claims appropriately if they have enough information to do so. In the case of re-routed claims, services submitted for payment are not considered claims under Medicare regulations until received by the appropriate Medicare contractor.

70.2.2 - Form Prescribed by CMS

(Rev. 3086, Issued: 10-03-14, Effective: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012, Implementation ICD-10: Upon Implementation of ICD-10; ASC X12: November 4, 2014)

Refer to section 2 for the acceptable claim formats. As noted in section 2, ASCA law requires that claims sent to Medicare be sent electronically unless an exception is met. Claims submitted on paper forms are entered into Medicare's electronic claims processing system and converted into electronic records in order to be processed. After the point of entry into the electronic system, handling of claims submitted on the prescribed electronic format and on its paper equivalent is identical with regard to determining timely filing. Regulations at 42 CFR 424.32 (b) prescribe the claim forms to be used for a paper claim submission.

70.2.3 - In Accordance with CMS Instructions

(Rev. 3086, Issued: 10-03-14, Effective: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012, Implementation ICD-10: Upon Implementation of ICD-10; ASC X12: November 4, 2014)

The CMS instructions for submitting institutional claims to Medicare are contained in this manual. General instructions that reflect guidance on reporting institutional claim data are found in Chapter 25. These instructions apply to all institutional claim types, whether paper or electronic. Additional chapters in this manual supplement these general instructions. For example, see instructions for inpatient hospital billing in Chapter 3, or inpatient skilled nursing billing in Chapter 6. General information about billing for physician and other supplier services and about the CMS 1500 claim form can be found in Chapter 26, Completing and Processing Form CMS-1500 Data Set, as well as chapters throughout this manual relative to specific policies and topics. For example see Chapter

12, Physicians/Nonphysician Practitioners, Chapter 13, Radiology Services and Other Diagnostic Services, or Chapter 16, Laboratory Services for detailed instructions for specific services.

In order to constitute a Medicare claim, services submitted for payment must be submitted to the appropriate Medicare contractor (§70.2.1), in a proper claim format (§70.2.2), and in accordance with these CMS claim completion instructions. Services submitted for payment in a manner not complete and consistent according to these instructions will not be accepted into Medicare's electronic claims processing system and will not be considered filed for purposes of determining timely filing.

70.2.3.1 - Incomplete or Invalid Submissions

(Rev. 4201, Issued: 01-18-19, Effective: 02-19-19, Implementation: 02-19-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

Services not submitted in accordance with CMS instructions include:

- Incomplete Submissions - Any submissions missing required information (e.g., no provider name).

- Invalid submissions - Any submissions that contains complete and required information; however, the information is illogical or incorrect (e.g., incorrect Medicare beneficiary identifier, invalid procedure codes) or does not conform to required claim formats.

The following definitions may be applied to determine whether submissions are incomplete or invalid:

- Required - Any data element that is needed in order to process the submission (e.g., Provider Name).

- Not Required - Any data element that is optional or is not needed in order to process the submission (e.g., Patient's Marital Status).

- Conditional - Any data element that must be completed if other conditions exist (e.g. if there is insurance primary to Medicare, then the primary insurer's group name and number must be entered on a claim). If these conditions exist, the data element becomes required.

Submissions that are found to be incomplete or invalid are returned to the provider (RTP). The incomplete or invalid information is detected by the FI's claims processing system. The electronic submission is returned to the provider of service electronically, with notation explaining the error(s). Assistance for making corrections is available in the on-line processing system (Direct Data Entry) or through the FI. In the limited cases where paper submission are applicable, paper submissions found to be incomplete or invalid prior to or during entry into the contractor's claims processing system are returned to the provider of service by mail, with an attached form explaining the error(s).

The electronic records of claims that are RTP are held in a temporary storage location in the FI's claims processing system. The records are held in this location for a period of time that may vary among FIs, typically 60 days or less. During this period, the provider may access the electronic record and correct it, enabling the submission to be processed by the FI. If the incomplete or invalid information is not corrected within the temporary storage period, the electronic record is purged by the FI. There is no subsequent audit trail or other record of the submission being received by Medicare. These submissions are never reflected on a RA. No permanent record is kept of the submissions because they are not considered claims under Medicare regulation.

70.2.3.2 - Handling Incomplete or Invalid Submissions

(Rev. 4201, Issued: 01-18-19, Effective: 02-19-19, Implementation: 02-19-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

The A/B MACs (A) should take the following actions upon receipt of incomplete or invalid submissions:

- If a required data element is not accurately entered in the appropriate field, RTP the submission to the provider of service.

- If a not required data element is accurately or inaccurately entered in the appropriate field, but the required data elements are entered accurately and appropriately, process the submission.

- If a conditional data element (a data element which is required when certain conditions exist) is not accurately entered in the appropriate field, RTP the submission to the provider of service.

- If a submission is RTP for incomplete or invalid information, at a minimum, notify the provider of service of the following information:

- Beneficiary's Name;
- Medicare beneficiary identifier;
- Statement Covers Period (From-Through);
- Patient Control Number (only if submitted);
- Medical Record Number (only if submitted); and
- Explanation of Errors.

NOTE: Some of the information listed above may in fact be the information missing from the submission. If this occurs, the A/B MAC (A) includes what is available.

- If a submission is RTP for incomplete or invalid information, the A/B MAC (A) shall not report the submission on the MSN to the beneficiary. The notice must only be given to the provider or supplier.

Refer to the implementation guide for the current ASC X12 837 institutional claim format for specifications. If a claim fails edits for any one of the content or size requirements, the A/B MAC (A) will RTP the submission to the provider of service.

NOTE: The data element requirements in the implementation guide may be superseded by subsequent CMS instructions. The CMS is continuously revising instructions to accommodate new data element requirements.

The A/B MACs (A) must provide a listing of the required data elements, including a brief explanation to providers and suppliers. A/B MACs (A) must educate providers regarding the distinction between submissions which are not considered claims, but which are returned to provider (RTP) and submissions which are accepted by Medicare as claims for processing but are not paid. Claims may be accepted as filed by Medicare systems but may be rejected or denied. Unlike RTPs, rejections and denials are reflected on RAs. Denials are subject to appeal, since a denial is a payment determination. Rejections may be corrected and re-submitted.

70.3 - Determining End Date of Timely Filing Period—Receipt Date
(Rev. 2140, Issued: 01-21-11, Effective: 01-01-10, Implementation: 02-22-11)

A submission, as defined above, is considered to be a filed claim for purposes of determining timely filing on the date that the submission is received by the appropriate Medicare claims processing contractor. At this point, the submission receives a permanent receipt date that remains part of the claim record. Once a submission (or claim) passes edits for completeness and validity described in §70.2 above, it is accepted into the Medicare claims processing system.

The receipt date has two functions. It is used for determining whether the claim was timely filed (see 70.4 below). The same date is also used as the receipt date for purposes of determining claims processing timeliness on the part of the intermediary. (See §80 for details on determining claims processing timeliness.)

70.4 - Determination of Untimely Filing and Resulting Actions
(Rev. 12909; Issued: 10-24-24; Effective: 11-26-24; Implementation: 11-26-24)

Medicare denies a claim for untimely filing if the receipt date applied to the claim exceeds 12 months or 1 calendar year from the date the services were furnished (i.e., generally, the "From" date, with the exception of the "Through" date for institutional claims that have span dates of services, as specified in §70.1). When a claim is denied for having been filed after the timely filing period, such denial does not constitute an "initial determination". As such, the determination that a claim was not filed timely is not subject to appeal.

Where the beneficiary request for payment was filed timely (or would have been filed timely had the provider taken action to obtain a request from the patient whom the provider knew or had reason to believe might be a beneficiary) but the provider is responsible for not filing a timely claim, the provider may not charge the beneficiary for the services except for such deductible and/or coinsurance amounts as would have been appropriate if Medicare payment had been made. In appropriate cases, such claims should be processed because of the spell-of-illness implications and/or in order to record the days, visits, cash and blood deductibles. The beneficiary is charged utilization days, if applicable for the type of services received.

70.5 - Application to Special Claim Types
(Rev. 12909; Issued: 10-24-24; Effective: 11-26-24; Implementation: 11-26-24)

- Adjustments - If a provider fails to include a particular item or service on its initial claim, an adjustment submission to include such an item(s) or service(s) is not permitted after the expiration of the time limitation for filing of the initial claim. There is no longer a timely filing period for adjustments. There are special timeliness requirements for filing adjustment requests for inpatient services subject to a prospective payment system, if the adjustment results in a change to a higher weighted DRG. These adjustments must be submitted within 60 days of the date of the remittance for the original claim, or the adjustment will be rejected.

- Reopenings - However, to the extent that an adjustment bill otherwise corrects or supplements information previously submitted on a timely claim about specified services or items furnished to a specified individual, it is subject to the rules governing administrative finality, rather than the time limitation for filing (see Chapter 34 on Re-openings). These claims must be submitted with a "Q" in the 4th position of the Type of Bill to identify them as a Reopening.

- Emergency Hospital Services and Services Outside the United States - The time limit for claims for payment for emergency hospital services and hospital services outside the United States, whether or not the hospital has elected to bill the program, is the same as for participating hospitals. (See §70.1 above.) The claim

for emergency hospital services and other services outside the United States will be considered timely filed if filed with any A/B MAC (A) within the time limit.

- Home health Requests for Anticipated Payment (RAPs) - Since by regulation RAPs are not claims for purposes of Title 18 of the Social Security Act, timely filing enforcement will be bypassed for any RAP for which the associated home health prospective payment system (HH PPS) claim could still be timely. RAPs for which the associated HH PPS claim could not still be timely will continue to be rejected, to prevent payment of RAP amounts that would be subject to recovery later.

70.6 - Filing Claim Where General Time Limit Has Expired
(Rev. 12909; Issued: 10-24-24; Effective: 11-26-24; Implementation: 11-26-24)

As a general rule, where the contractor receives a late filed claim submitted by a provider or supplier with no explanation attached as to the circumstances surrounding the late filing, the contractor should assume that the provider or supplier accepts responsibility for the late filing.

Where it comes to the attention of a provider or supplier that health services that are or may be covered were furnished to a beneficiary but that the general time limit (defined in §70.1 above) on filing a claim for such services has expired, the provider or supplier should take the following action.

- Where the provider or supplier accepts responsibility for late filing, it should file a no-payment claim. (See Chapter 3 for no-payment bill processing instructions.) Where the provider or supplier believes the beneficiary is responsible for late filing, it should contact the contractor and also file a no-payment claim and include a statement in the remarks field on the claim explaining the circumstances which led to the late filing and give the reasons for believing that the beneficiary (or other person acting for him/her) is responsible for the late filing. If a paper claim is submitted, such a statement may be attached and, if practicable, may include the statement of the beneficiary as to the beneficiary's view on these circumstances.

- Where the beneficiary does not agree with the determination that the claim was not filed timely or the determination that he/she is responsible for the late filing, the usual appeal rights are available to the beneficiary. Where the provider or supplier is protesting the denial of payment or the assignment of responsibility, no formal channels of appeal are available. However, the contractor may, at the request of the provider or supplier, informally review its initial determination.

70.7 - Exceptions Allowing Extension of Time Limit
(Rev. 12909; Issued: 10-24-24; Effective: 11-26-24; Implementation: 11-26-24)

Medicare regulations at 42 C.F.R. §424.44(b) allow for the following exceptions to the 1 calendar year time limit for filing fee for service claims:

(1) Administrative error, if failure to meet the filing deadline was caused by error or misrepresentation of an employee, Medicare contractor, or agent of the Department that was performing Medicare functions and acting within the scope of its authority (See 70.7.1).

(2) Retroactive Medicare entitlement, where a beneficiary receives notification of Medicare entitlement retroactive to or before the date the service was furnished. For example, at the time services were furnished the beneficiary was not entitled to Medicare. However, after the timely filing period has expired, the beneficiary subsequently receives notification of Medicare entitlement effective retroactively to or before the date of the furnished service (See 70.7.2).

(3) Retroactive Medicare entitlement involving State Medicaid Agencies, where a State Medicaid Agency recoups payment from a provider or supplier 6 months or more after the date the service was furnished to a dually eligible beneficiary. For example, at the time the service was furnished the beneficiary was only entitled to Medicaid and not to Medicare. Subsequently, the beneficiary receives notification of Medicare entitlement effective retroactively to or before the date of the furnished service. The State Medicaid Agency recoups its money from the provider or supplier and the provider or supplier cannot submit the claim to Medicare, because the timely filing limit has expired (See 70.7.3).

(4) Retroactive disenrollment from a Medicare Advantage (MA) plan or Program of All-inclusive Care of the Elderly (PACE) provider organization, where a beneficiary was enrolled in an MA plan or PACE provider organization, but later was disenrolled from the MA plan or PACE provider organization retroactive to or before the date the service was furnished, and the MA plan or PACE provider organization recoups it payment from a provider or supplier 6 months or more after the date the service was furnished (See 70.7.4).

The conditions for meeting each exception, and a description of how filing extensions will be calculated, are described in sections 70.7.1 – 70.7.4.

Where the initial request for an exception to the timely filing limit is made by a provider or supplier, the Medicare contractor has responsibility for determining whether a late claim may be honored based on all pertinent documentation submitted by the provider or supplier, and for the exceptions described in sections 70.7.2 and 70.7.3, based on its review of the relevant information contained in the Common Working File (CWF) database. As explained in sections 70.7.1 – 70.7.4, the contractor will determine if the requirements for a particular exception are met. However, in certain circumstances, the contractor may contact the appropriate CMS regional office (RO) to ascertain whether it wants to participate in the review and decision-making of the specific exception request. In limited circumstances, the RO may conclude that the exception request should go to CMS Central Office for a final determination.

70.7.1 - Administrative Error
(Rev. 2140, Issued: 01-21-11, Effective: 01-01-10, Implementation: 02-22-11)

Medicare regulations at 42 CFR 424.44 allow that where Medicare program error causes the failure of the provider or supplier to file a claim for payment within the time limit in §70.1 above, the time limit will be extended through the last day of the 6th calendar month following the month in which the error is rectified by notification to either the provider, supplier, or beneficiary. In order to avoid having two extension of time triggers, contractors must notify the beneficiary and the provider or supplier in writing about the correction of the error on the same day. Administrative error may include misrepresentation, delay, mistake, or other action of Medicare, or its contractors. Contractors will not accept requests for extensions for such errors that extend beyond 4 years from the date of service.

The administrative error that prevents timely filing of the claim may affect the provider or supplier directly or indirectly, i.e., by preventing the beneficiary or his or her representative from filing a timely request for payment. Situations in which failure to file within the usual time limit will be considered to have been caused by administrative error include but are not limited to the following:

- The failure resulted from misinformation from an employee, Medicare contractor, or agent of the Department acting within the scope of its authority, e.g., that certain services were not covered under Part A or Part B, although in fact they were covered.

- The failure resulted from excessive delay by Medicare, or the Medicare contractor in furnishing information necessary for the filing of the claim.

- The failure resulted from advice by an employee, Medicare contractor, or agent of the Department acting within the scope of its authority that precluded the filing of a claim until the provider or supplier receives certain information from the Medicare contractor (e.g., a hospital following manual instructions does not file a billing for outpatient services where the services are expected to be paid for by workmen's compensation; but the hospital learns after the expiration of the time limit of the ultimate denial of workmen's compensation liability).

- Any claim involving situations other than those listed above, where it appears that an extension of the time limit might be justified on the basis of administrative error, should be submitted by the appropriate Medicare claims processing contractor with a recommendation, before payment, to the appropriate CMS RO. Contractors should consult with the appropriate RO. ROs may in turn consult with CMS Central Office.

Where administrative error is alleged to be responsible for late filing, the necessary evidence would ordinarily include:

- A statement from the beneficiary, his/her representative or the provider or supplier, depending on whom the error directly affected, as to how he/she learned of the error, and when it was corrected, and one of the following:

    - A written report by Medicare or the Medicare contractor describing how its error caused failure to file within the time limit; or

    - Copies of a CMS or Medicare contractor letter or other written notice reflecting the error, or

    - A written statement of an agency employee having personal knowledge of the error.

However, the statement of the beneficiary, his/her representative, or the provider or supplier is not essential if the other evidence establishes that his/her failure to file within the usual time limit resulted from administrative error, and that he/she filed a claim within six months after the month in which he/she was notified that the error was corrected. There must be a clear and direct relationship between the administrative error and the late filing of the claim. Where the evidence is in the Medicare contractor's own records, it should annotate the claims file to this effect.

If the claims processing contractor determines that a late claim should be honored because the facts support that an error or misrepresentation has caused the claim to be late, the provider, supplier, or beneficiary will have until the end of the 6th calendar month from the month in which the provider, supplier, or beneficiary received notification that the error or misrepresentation has been corrected.

70.7.2 – Retroactive Medicare Entitlement

(Rev. 2477, Issued: 05-25-12, Effective: 08-27-12 Implementation: 08-27-12)

The time for filing a claim will be extended if CMS or one of its contractors determines that a failure to meet the filing deadline is caused by all of the following conditions:

(a) At the time the service was furnished the beneficiary was not entitled to Medicare.

(b) The beneficiary subsequently received notification of Medicare entitlement effective retroactively to or before the date of the furnished service.

Thus, a provider or supplier may have furnished services to an individual who was not entitled to Medicare. More than a year later, the individual receives notification from SSA that he or she is entitled to Medicare benefits retroactive to or before the date he or she received services from the provider or supplier. In this situation, the provider or supplier may submit a request for a filing extension to the appropriate Medicare claims processing contractor, as long as the provider or supplier submits supporting documentation that verifies that the conditions above are met.

If the beneficiary and the provider or supplier is notified on different days about the beneficiary's retroactive Medicare entitlement, there will be two extensions of time triggers. One extension of time trigger is when the beneficiary is first notified about the beneficiary's retroactive Medicare entitlement and the other extension of time trigger is when the provider or supplier is the first party notified of the beneficiary's retroactive Medicare entitlement. If the beneficiary is submitting the claim, the time to file the claim is based on the day the beneficiary is first notified of the retroactive Medicare entitlement. If the provider or supplier is submitting the claim, the time to file the claim is based on the day the provider or supplier is first notified of the retroactive Medicare entitlement.

Where retroactive Medicare entitlement is alleged, the provider, supplier, or beneficiary will need to provide the contractor with the following information:

- an official Social Security Administration (SSA) letter notifying the beneficiary of Medicare entitlement and the effective date of the entitlement; and,

- documentation describing the service/s furnished to the beneficiary and the date of the furnished service/s.

If the provider, supplier, or beneficiary is unable to provide the contractor with an official SSA letter, the Medicare contractor shall check the Common Working File (CWF) database and may interpret the CWF date of accretion and the CWF Medicare entitlement date for a beneficiary in order to verify a beneficiary's retroactive entitlement. For example, if the CWF indicates a Medicare entitlement date of March 1, 2008 and a date of accretion of December 14, 2010, then the contractor may interpret the CWF data to mean that the beneficiary was retroactively entitled to Medicare as of March 1, 2008 and that this data was added to the CWF database on December 14, 2010. If the contractor has any problems or concerns with respect to interpreting the CWF data, then the contractor should consult with the appropriate CMS regional office.

If the contractor determines that both of the conditions for meeting this exception described above are met, the time to file a claim will be extended through the last day of the 6th calendar month following the month in which either the beneficiary or the provider or supplier received notification of Medicare entitlement effective retroactively to or before the date of the furnished service.

70.7.3 – Retroactive Medicare Entitlement Involving State Medicaid Agencies

(Rev. 2477, Issued: 05-25-12, Effective: 08-27-12 Implementation: 08-27-12)

The time for filing a claim will be extended if CMS or one of its contractors determines that failure to meet the filing deadline is caused by all of the following conditions:

(a) At the time the service was furnished the beneficiary was not entitled to Medicare.

(b) The beneficiary subsequently received notification of Medicare entitlement effective retroactively to or before the date of the furnished service.

(c) A State Medicaid Agency recovered the Medicaid payment for the furnished service from a provider or supplier 6 months or more after the date of the furnished service.

In these situations, at the time services were furnished the beneficiary was entitled to Medicaid but not to Medicare. After the date of the furnished services, the beneficiary is then notified that he or she is entitled to Medicare. Finally, sometime after the date of the furnished service, the State Medicaid Agency recoups the money it paid the provider or supplier. If the State Medicaid Agency recoups the money it paid the provider or supplier 6 months or more after the date the service was furnished, the provider or supplier may be given an extension to have those claims filed to Medicare.

In order to qualify for this exception, the provider or supplier will need to provide the claims processing contractor with the following information:

- documentation verifying the date that the State Medicaid Agency recouped money from the provider/supplier;

- documentation verifying that the beneficiary was retroactively entitled to Medicare to or before the date of the furnished service (e.g., an official SSA letter to the beneficiary, or if an official SSA letter is not available, the contractor shall check the CWF database and may interpret the CWF date of accretion and the CWF Medicare entitlement date for a beneficiary in order to verify a beneficiary's retroactive entitlement; see the example in section 70.7.2 above concerning the CWF for additional details regarding this contractor verification process); and,

- documentation verifying the service/s furnished to the beneficiary and the date of the furnished service/s.

If the contractor determines that all of the conditions described above for meeting this exception are met, the contractor will notify the provider or supplier in writing that a filing extension will be allowed from the end of the 6th calendar month from the month in which the State Medicaid Agency recovered its money.

70.7.4 - Retroactive Disenrollment from a Medicare Advantage plan or Program of All-inclusive Care for the Elderly (PACE) Provider Organization

(Rev. 2140, Issued: 01-21-11, Effective: 01-01-10, Implementation: 02-22-11)

The time for filing a claim will be extended if CMS or one of its contractors determines that a failure to meet the filing deadline is caused by all of the following conditions:

(a) At the time the service was furnished the beneficiary was enrolled in a Medicare Advantage (MA) plan or Program of All-inclusive Care for the Elderly (PACE) provider organization.
(b) The beneficiary was subsequently disenrolled from the Medicare Advantage plan or Program of All-inclusive Care for the Elderly (PACE) provider organization effective retroactively to or before the date of the furnished service.
(c) The Medicare Advantage plan or Program of All-inclusive Care for the Elderly (PACE) provider organization recovered its payment for the furnished service from a provider or supplier 6 months or more after the service was furnished.

There may be situations where a beneficiary is enrolled in an MA plan or in a PACE provider organization, and later becomes disenrolled from the MA plan or PACE provider organization. And, if the MA plan or the PACE provider organization recoups the money it paid the provider or supplier 6 months or more after the service was furnished, the provider or supplier may be granted an exception to have those claims filed with Medicare.

In order to qualify for this exception, the provider or supplier will need to provide the claims processing contractor with information that verifies:

- prior enrollment of the beneficiary in an MA plan or PACE provider organization;
- the beneficiary, the provider, or supplier was notified that the beneficiary is no longer enrolled in the MA plan or PACE provider organization;
- the effective date of the disenrollment; and,
- the MA plan or PACE provider organization recouped money from the provider or supplier for services furnished to a disenrolled beneficiary.

If the contractor determines that all of the conditions described above are satisfied, the contractor will notify the provider or supplier in writing that a filing extension will be allowed from the end of the 6th calendar month from the month in which the MA plan or PACE provider organization recouped its money from the provider or supplier.

70.8 - Filing Request for Payment to Carriers—Medicare Part B
(Rev. 2140, Issued: 01-21-11, Effective: 01-01-10, Implementation: 02-22-11)

Medicare regulations at 42 CFR 424.44 define the timely filing period for Medicare fee-for-service claims. Such claims must be filed no later than 12 months (or 1 calendar year) after the date the services were furnished.

70.8.1 – Splitting Claims for Processing
(Rev. 3389, Issued: 10-30-15, Effective: 01-01-14, Implementation: 04-04-16)

There are a number of prescribed situations where a claim is received for certain services that require the splitting of the single claim into one or more additional claims. The splitting of such a claim is necessary for various reasons such as proper recording of deductibles, separating expenses payable on a cost basis from those paid on a charge basis, or for accounting and statistical purposes. Split a claim for processing in the following situations:

- Expenses incurred in different calendar years cannot be processed as a single claim. A separate claim is required for the expenses incurred in each calendar year;

EXCEPTION FOR DURABLE MEDICAL EQUIPMENT REGIONAL CARRIERS (DMERCs):

Expendable items (disposable items such as blood glucose test strips and PEN nutrients) that will be used in a time frame that spans two calendar years and are required to be billed with appropriately spanned "from" and "to" dates of service may be processed on a single claim line. For these types of items, DMERCs must base pricing and deductible calculations on the "from" date, since that is the date when the item was furnished.

- A claim other than a DMERC claim that spans two calendar years where the "from" date of service is untimely but the "to" date of service is timely should be split and processed as follows:

    1. Where the number of services on the claim is evenly divisible by the number of days spanned, assume that the number of services for each day is equal. Determine the number of services per day by dividing the number of services by the number of days spanned. Then split the claim into a timely claim and an untimely claim. Deny the untimely claim and process the timely claim.

    2. Where the number of services on the claim is not evenly divisible by the number of days spanned and it is not otherwise possible to determine from the claim the dates of services, suspend and develop the claim in order to determine the dates of services. After determining the dates of services, split the claim accordingly into a timely claim and an untimely claim. Deny the untimely claim and process the timely claim.

- A claim containing both assigned and unassigned charges. Split assigned and unassigned services from non-participating physicians/suppliers into separate assigned and unassigned claims for workload counts and processing;

- Assigned claims from different physicians/suppliers (excluding group practices and persons or organizations to whom benefits may be reassigned). Process a separate claim for the services from each physician/supplier. Where the assigned claim is from a person or organization to which the physicians performing the

services have reassigned their benefits, process all of the services as a single claim;

- A claim where there is more than one beneficiary on a single claim. There can only be one beneficiary per claim; and

NOTE: Roster bills for covered immunization services furnished by mass immunizers may be submitted for multiple beneficiaries. You must create individual claims for each Medicare beneficiary based on the roster bill information.

- Outpatient physical therapy services furnished on a cost basis by a physician-directed clinic cannot be processed when combined on the same claim with other charge-related services by the clinic. Process the cost related services as a separate claim.

- If an unassigned claim includes services by an independent physical therapist together with other physician services, process the physical therapy services as a separate claim. Process an assigned claim from an independent physical therapist as a single claim.

- A claim that is a duplicate of a claim previously denied is treated as a new claim if there is no indication that the claim is a resubmittal of a previous claim with additional information, or there is no indication on the second claim that the beneficiary is protesting the previous determination.

- In a claim containing services from physicians/suppliers covering more than one carrier jurisdiction, the carrier receiving the claim must split off the services to be forwarded to another contractor and count the material within the local jurisdiction as a claim. The carrier receiving the transferred material must also count it as a separate claim.

- When services in a claim by the same physician/supplier can be identified as being both second/third opinion services and services not related to second/third opinion, the "opinion" services must be split off from the "non-opinion" services and counted as a separate claim. When one physician/supplier in an unassigned claim has provided the "opinion" service and another physician(s)/supplier(s) has provided the "non-opinion" services, the claim may not be split.

- Claims containing any combination of the following types of services must be split to process each type of service as a separate claim. These services are:

  -- Physical therapy by an independent practitioner, **or**

  -- any services paid at l00 percent of reasonable charges.
  (Any of these types of services may be combined on the same claim with any other type of service.)

Do not deviate from defining claims as described above. Split claims in accordance with the appropriate definition. Throughout the claims process count each of the separate claims, resulting from the split, as an individual claim.

70.8.2 - Replicating Claims for Processing
(Rev. 170, 05-07-04)

There are no prescribed reasons other than those aforementioned for splitting claims and for counting additional claims into your workload. However, claims are frequently split for other reasons that are dictated by the systems or the methods of processing them. Such additional claims are labeled "Replicate Claims." Tally and report all replicate claims (other than those aforementioned) separately. Identify replicate claims and report them in the appropriate categories for claims. Some examples of replicate claims are:

- Additional claims created because of a line item limitation (regardless of the methodology used for coding line items);
- Extra claims created in making partial payments;
- Claims created for carving out individual specialty types of services and
- Extra claims created to apply special payment reductions (e.g., Gramm-Rudmann-Hollings) efficiently for applicable dates of service.

NOTE: For budget requests and cost reports (CMS-l524, CMS-l528, CMS-l6l6, and CMS-2599), the workload must exclude the number of replicate claims produced.

70.8.3 - Methods of Claiming Benefits for Services by Physicians and Suppliers
(Rev. 12909; Issued: 10-24-24; Effective: 11-26-24; Implementation: 11-26-24)

The method of claiming Part B benefits depends upon whether the patient is claiming payment or is assigning benefit payments to his/her source of medical treatment or services.

As a rule, beneficiaries do not submit claims for reimbursement. However, if there is reason for a beneficiary to submit a claim for reimbursement, the beneficiary uses the CMS-1490S. For covered services furnished on or after September 1, 1990, physicians and suppliers must complete and submit in accordance with SSA §1848(g)(4)(A) all Part B claims whether assigned or unassigned for beneficiaries who desire Medicare benefit payment determinations.

The physician/supplier or the facility or organization to which the physician may reassign benefits, claims the payment. The patient or his representative agrees to assign the

benefits and the physician/supplier agreeing to the assignment accepts the Medicare reasonable charge determination as the full charge for the services. (See §§30.2 through 30.3.8 about specific assignment procedures and the nature and effect of assignments.)

70.8.4 - Claims Forms CMS-1490S and CMS-1500

(Rev.: 4388; Issued: 09-06-19; Effective: 10-07-19; Implementation: 10-07-19)

A number of prescribed claims forms have been developed for use when requesting payment for Part B Medicare services. Many are printed and distributed nationally free of cost through CMS's Printing and Publications Branch. (See NOTE below for exception.)

In order to maintain control over the content and format of the forms, private printing of a Government form is not routinely permitted. However, if you or another organization wishes to independently print a prescribed claims form, the reproduction of a claims form must be in accordance with §422.527 of Title 20, Chapter III, Part 422 of the Code of Federal Regulations. Obtain CMS approval for printing a prescribed form. Route the written request for approval through the RO. Include the following:

- The reason or need for such reproduction;
- The intended user of the form;
- The proposed modifications or format changes, with printing or other specifications (such as realignment of data or line designations);
- The type of automatic data processing machinery, if any, for which the form is designed; and
- Estimates of printing quantity, cost per thousand, and annual usage.

NOTE: This procedure does not apply to the Form CMS-1500, Health Insurance Claim Form. A/B MACs (B), physicians and suppliers are responsible for purchasing their own forms. This form can be bought in single, multipart snap-out sets or in continuous pin-feed format. Medicare accepts any version. Forms can be obtained from local printers or printed in-house as long as it follows the CMS approved specifications developed by the National Uniform Claim Committee.

The Form CMS-l490 was formerly the basic Part B claims form. It was replaced by Form CMS-l500 for claims completed by physicians and suppliers (except ambulance suppliers), and Form CMS-l490S for claims from beneficiaries. You must, however, continue to accept and process claims received on Form CMS-1490 form after conversion to Forms CMS-l500 and CMS-l490S.

The Form CMS-1500 (Health Insurance Claim Form) is the prescribed form for claims prepared and submitted by physicians or suppliers (except for ambulance services),

whether or not the claims are assigned. It can be purchased in any version required i.e., single sheet, snap-out, continuous, etc.

The forms described below are printed and distributed to contractors by CMS and are available in single sheets, multipart snap-out sets, or in pin-feed format.

The Form CMS-1490S (Patient's Request for Medical Payment) form is used only by beneficiaries (or their representatives) who complete and file their own claims. It contains the patient's comparable items of data that are on the Form CMS-1500. When the Form CMS-1490S is used, an itemized bill must be submitted with the claim. Social Security Offices use the Form CMS-1490S when assisting beneficiaries in filing Part B Medicare claims. For Medicare covered services received on or after September 1, 1990, the Form CMS-1490S is used by beneficiaries to submit Part B claims only if the service provider refuses to do so. Inasmuch as the Form CMS-1490S has no provision for a diagnosis code, the diagnosis code is not required at the time of claim submission.

CMS implemented a new version of the Form CMS-1490S effective January 1, 2019. The revised form is version 01/18, OMB control number 0938-1197. The revised form will replace the previous version of the form 01/05, OMB control number 0938-0999.

The term, "Form CMS-1490S" refers to the form generically, independent of a given version.

Medicare will conduct a dual-use period (January 1, 2019 through March 31, 2019) during which Beneficiaries (or their representatives) can send Medicare claims on either the old or the revised form. When the dual-use period is over, Medicare will accept beneficiary paper claims on only the revised Form CMS-1490S, version 01/18.

The Form CMS-1556 (Prepayment Plan for Group Practices Dealing Through An A/B MAC (B)) is used by plans which, for Medicare purposes are, both Group Practice Prepayment Plans, and are paid on the basis of reasonable charges related to their costs for furnishing services to their subscribers.

70.8.5 – Photocopies
(Rev. 170, 05-07-04)

Some enrollees may want to keep the original itemized physician and supplier bills for income tax or complementary insurance purposes. Photocopies of itemized bills are acceptable for Medicare deductible and payment purposes if there is no evidence of alteration.

70.8.6 – Penalty for Filing Claims after One Year
(Rev. 2140, Issued: 01-21-11, Effective: 01-01-10, Implementation: 02-22-11)

Section 1848(g)(4) of the Social Security Act (the Act) requires that physicians and suppliers complete and submit Part B claims for medical services, equipment and

supplies (furnished on or after September 1, 1990) within 12 months of the service date. Only assigned claims submitted more than 12 months after the service date will be subject to a 10 percent reduction of the amount that would otherwise have been paid. Payment on an assigned claim submitted by a physician or other supplier 12 months or longer after the service is furnished, shall be reduced by 10 percent from the amount that would have otherwise been paid. On March 23, 2010, Congress passed the Patient Protection and Affordable Care Act (the Affordable Care Act). Section 6404 of the Affordable Care Act amended sections 1814(a)(1), 1835(a)(1), and 1842(b)(3)(B) of the Act, by reducing the maximum time period for filing Medicare Part A and Part B claims to no more than 12 months after the date of service. Therefore, this nullifies the 10 percent reduction requirement on physician and supplier claims submitted after 12 months from the date of service, because the claim will be denied as untimely filed; unless, an exception for the late filing is granted. And, if an exception for late filing is granted, then the 10 percent penalty is waived.

70.8.6.1 – Monitoring Claims Submission Violations

(Rev. 12909; Issued: 10-24-24; Effective: 11-26-24; Implementation: 11-26-24)

A. General

Section 1848(g)(4) of the Social Security Act requires physicians and suppliers to submit claims to Medicare carriers for services furnished on or after September 1, 1990. It also prohibits physicians and suppliers from imposing a charge for completing and submitting a claim. Physicians and suppliers who fail to submit a claim or who impose a charge for completing the claim are subject to sanctions. CMS is responsible for assessing sanctions and monetary penalties for noncompliance.

Physicians and suppliers are not required to take assignment of Medicare benefits unless they are enrolled in the Medicare Participating Physician and Supplier Program or, in the case of physician services, the Medicare beneficiary is also a recipient of State medical assistance (Medicaid) or the service is otherwise subject to mandatory assignment.

B. Compliance Monitoring

To ensure that providers and suppliers are enrolled in the Medicare program and submit claims in compliance with the mandatory claims submission requirements found in §1848(g)(4) of the Social Security Act, contractors shall:

1) Process beneficiary claims submitted to A/B MACs or carriers for services that are <u>not</u> covered by Medicare (e.g., for hearing aids, cosmetic surgery, personal comfort services, etc.; see 42 CFR 411.15 for details), in accordance with its normal processing procedures;

2) Process beneficiary claims submitted to A/B MACs or carriers for services that are covered by Medicare and the beneficiary has submitted a complete and valid

claim (Form CMS-1490S) and all supporting documentation associated with the claim, including an itemized bill with the following information:

- Date of service,
- Place of service,
- Description of illness or injury,
- Description of each surgical or medical service or supply furnished,
- Charge for each service,
- The doctor's or supplier's name and address,
- The provider or supplier's National Provider Identifier (NPI)
- The ordering & referring provider's legal name and address and the National Provider Identifier (NPI) if known when the itemized bill is from:
  A Clinical laboratory for ordered tests
  An independent diagnostic imaging center for ordered imaging procedures
  A supplier of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) for ordered DMEPOS

If the beneficiary furnishes all other information but fails to supply the provider or supplier's NPI the contractor shall not return the claim but rather look up the provider or supplier's NPI using the NPI registry. If the contractor determines that the provider or supplier was not a Medicare enrolled provider with a valid NPI, the contractor shall follow previously established procedures in order to process and adjudicate the claim.

3) Retain the Form-1490S and supporting documentation and manually return a copy to the beneficiary if it is for a Medicare-covered service and the claim is incomplete, does not include all required supporting documentation and/or contains invalid information. Contractors shall also include an appropriate letter that specifically communicates all the items listed above which were missing or invalid. In addition, the CMS-1490S and supporting documentation shall be maintained for purposes of the timely filing rules in the event that the beneficiary re-submits the claim.

   If the Beneficiary submits a claim on the English or Spanish Form CMS-1490S (version 01/05) on or after April 1, 2019, manually return the Form CMS-1490S (version 01/05) claim to the beneficiary, and include a copy of the Form CMS-1490S (version 01/18), along with a letter instructing the beneficiary to complete and return the Form CMS-1490S (version 01/18) for processing within the time period prescribed in §70.5.

   If a beneficiary submits a claim on the Form CMS-1500, manually return the Form CMS-1500 claim to the beneficiary, and include a copy of the Form CMS-1490S, along with a letter instructing the beneficiary to complete and return the Form CMS-1490S for processing within the time period prescribed in §70.5, above. Include in the letter a description of missing, invalid or incomplete items

required for the Form CMS-1490S that were not included with the submitted Form CMS-1500 or were invalid.

4) Retain Medicare claims records using the following disposition rules.

DISPOSITION:

1. Carriers who Microform Claims

a) Hardcopy Records - Cut off no later than the close of the calendar year (CY) in which paid. The hardcopy claim must be retained in accordance with the following:

(1) If a corresponding master microfilm has been made and verified, transfer to a Federally-approved records storage facility or hold onsite. Destroy after a total retention of 3 years after the close of the CY in which paid.

(2) If a corresponding master microform record has NOT been made and verified, transfer to a Federally-approved records storage facility or hold onsite. Destroy after a total retention of 6 years and 3 months after the close of the CY in which paid.

b) Microform Records

The master microform record must be retained for a total retention of 6 years and 3 months following the close of the calendar year in which paid.

2. Carriers Who Do Not Microfilm Claims Records

Cut off at the close of the calendar year (CY) in which paid, then transfer to a Federally-approved records storage facility. Destroy after a total retention of 6 years and 3 months. Earlier cutoff and transfer is authorized. However, the records must be retained for a total retention of 6 years and 3 months following the close of the calendar year in which payment is made.

a) Hardcopy Records - The hardcopy must be retained onsite until the microform has been verified. Cut off at the close of the calendar year in which paid; transfer hardcopy to a Federally-approved records storage facility only if there is a corresponding master microfilm record that can be retained for the period indicated in b. below; otherwise, the hardcopy shall be retained until the 6 years and 3 months period is reached. Earlier cutoff and transfer is authorized. However, the hardcopy must be retained for a total retention of 3 years after the close of the calendar year in which paid.

b) Microform Records - The master microform records must be retained for a total retention of 6 years and 3 months following the close of the calendar year in which payment is made.

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

If a beneficiary receives services from a provider or supplier that refuses to submit a claim to the A/B MAC or carrier, on the beneficiary's behalf, (for services that would otherwise be payable by Medicare), and/or refuses to enroll in the Medicare program, the beneficiary should:

(1) Notify the contractor in writing that the provider or supplier refused to submit a claim to Medicare and/or refused to enroll in Medicare, and

(2) Submit a complete Form CMS-1490S with all supporting documentation.

The contractor shall process and pay the beneficiary's claim if it is for a service that would be payable by Medicare were it not for the provider or supplier's refusal or inability to submit the claim and/or enroll in Medicare. Claims shall be adjudicated based on whether the service provided is covered or non-covered/excluded rather than on the provider's enrollment status. If for a covered service, the claim shall be processed and the allowed amount reimbursed to the beneficiary, if appropriate. If for a non-covered/excluded service, the claim shall be processed and denied with an appropriate MSN message. For sanctioned/excluded and opt-out physicians/practitioners the following MSN messaging is recommended:

<u>Sanctioned/Excluded provider or supplier:</u>

A sanctioned or excluded provider or supplier is an individual or business excluded from participation in the Medicare program for a stated period of time as a result of fraudulent activity, program abuse, or impermissible conduct as determined by OIG. CMS will pay the first claim submitted by a beneficiary for the services of a sanctioned/excluded physician or practitioner and immediately notify the sanctioned/excluded physician or practitioner of the exclusion. CMS will not pay a claim for sanctioned/excluded physician or practitioner services more than 15 days after the date on the notice to the physician or practitioner, or after the effective date of the exclusion, whichever is later. Under no circumstance may Medicare payment be made to any entity, including beneficiaries, for services rendered by such providers or suppliers after the first claim is paid. An example of language that may be considered:

MSN Message 21.27

<u>English</u>

Services provided by a Medicare sanctioned/excluded provider or supplier. No Medicare payment may be made.

Spanish
Los servicios fueron brindado por un proveedor excluído de Medicare, por lo tanto Medicare no pagó por los servicios.

Opt-Out physicians and practitioners:

Medicare payment may be made for the claims submitted by a beneficiary for the services of an opt out physician or practitioner when the physician or practitioner did not privately contract with the beneficiary for services that were not emergency care services or urgent care services and that were furnished no later than 15 days after the date of a notice by the carrier that the physician or practitioner has opted out of Medicare (see 42 C.F.R. 405.435(c)). Therefore, if the beneficiary submits a claim for a service that was furnished by an opt out physician or practitioner, then the carrier must contact the opt out physician or practitioner in order to ascertain whether the beneficiary entered into a private contract with the opt out physician or practitioner. (Note: The carrier should obtain a copy of the private contract from the opt out physician/practitioner before denying the beneficiary's claim if the beneficiary did, in fact, enter into a private contract with the physician or practitioner.) If the beneficiary did not enter into a private contract with the physician or practitioner and the beneficiary did not receive notice from the carrier that the physician opted out of Medicare, then Medicare payment may be made to the beneficiary for the non-emergency and/or non-urgent care services (assuming that the services would otherwise be payable). On the other hand, if the beneficiary did enter into a private contract with the physician or practitioner for the services or received services from the physician/practitioner 15 days after the date of a notice by the carrier that the physician or practitioner has opted out of Medicare, then no Medicare payment may be made. Medicare has instructed opt out physicians and practitioners that private contract language must include beneficiary instruction precluding the beneficiary from billing Medicare for these services. An example of language that may be considered:

MSN Message 21.26

English
Claim denied because services were provided by an Opt-Out physician or practitioner. No Medicare payment may be made.

Spanish
La reclamación fue denegada porque los servicios fueron brindados por un médico ó proveedor que decidió no participar en Medicare, por lo tanto, Medicare no pagó por los servicios.

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

Contractors are encouraged to educate providers and suppliers that they must be enrolled in the Medicare program before they submit claims for services furnished or supplied to any Medicare beneficiary.

The above policy, including the NPI requirement, is not applicable for foreign beneficiary claims submitted for covered services. These claims should be processed using guidelines for foreign claims.

The above policy, including the NPI requirement, is not applicable to beneficiary claims submitted to DMEMACs for durable medical equipment, prosthetics, orthotics, and supplies. These claims should be processed by DMEMACs using current procedures.

C. Exception When Physician, Other Practitioner, or Supplier Is Excluded From Participating in Medicare Program

Section 1848(g)(4) of the Social Security Act requires physicians, other practitioners, or suppliers to submit claims to Medicare carriers for services furnished after September 1, 1990. This **does not** apply to physicians, other practitioners, or suppliers who have been excluded from participating in the Medicare program. Physicians, other practitioners, and suppliers who have been excluded from the Medicare program are prohibited from submitting claims or causing claims to be submitted. See the Medicare Program Integrity Manual for procedures concerning claims submitted by an excluded practitioner, his/her employer, or a beneficiary for services or items provided by an excluded physician, other practitioner, or supplier. Carriers must maintain the systems capability to identify claims submitted by excluded physicians, other practitioners, or suppliers as well as items or services provided, ordered, prescribed, or referred by an excluded party.

When an excluded physician, other practitioner, or supplier has not submitted a claim on behalf of the beneficiary and/or the beneficiary has submitted the claim themselves, do **not** send a notification letter to the physician, other practitioner, or supplier warning of civil monetary penalties due to noncompliance with §1848(g)(4)(A) of the Act. Instead, follow the instructions in the Program Integrity Manual.

70.8.6.2 – Notification Letters

(Rev. 12909; Issued: 10-24-24; Effective: 11-26-24; Implementation: 11-26-24)

A. The letter sent to the beneficiary should explain why the claim is being returned including an explanation of the corrections needed in order to process the claim. Also, include an explanation of the statutory requirement that providers and suppliers must submit claims for all covered services provided to Medicare beneficiaries. The letter should also provide the beneficiary with instructions on what should be done if the provider or supplier refuses to enroll with Medicare and/or submit the claim.

B. A letter shall also be sent to the provider or supplier explaining the statutory requirement for submitting claims for all services rendered to Medicare beneficiaries.

The letter should explain to the provider or supplier that they are required to enroll with the Medicare program before a claim can be submitted. Finally the letter should include language explaining the penalties for failure to comply with the mandatory claims submission requirements.

70.8.6.3 - Violations That Are Not Developed For Referral

(Rev. 12909; Issued: 10-24-24; Effective: 11-26-24; Implementation: 11-26-24)

Claim submission violations need not be developed on beneficiary-submitted Form CMS-1490S claims that include approved charges for services performed on or after September 1, 1990 in the following situations:

- Used DME purchases from private sources;

- Cases in which a physician/supplier does not possess information essential for filing a MSP claim. Assume this is the case if the beneficiary files a MSP claim and encloses the primary insurer's payment determination notice and there is no indication that the service provider was asked to file but refused to do so;

- Services paid under the indirect payment procedure;
- Foreign claims; and
- Other unusual or unique situations that you evaluate on a case-by-case basis.

NOTE: It is unlikely that knowing, willful, and repeated noncompliance will apply in the above situations.

80 - Carrier and FI Claims Processing Timeliness

(Rev. 1, 10-01-03)

A3-3600, A3-3600.1, B3-13306, HO-401, HO-401A, HH-462, B2-5240.11

Carriers and FIs must establish control records for timely claims processing as described below.

80.1 - Control and Counting Claims

(Rev. 1, 10-01-03)

The carrier or FI will consider claims as received for timely processing purposes from the date of their receipt. Improperly completed claims that it returns are considered received for timely processing purposes when received again, properly completed.

A. Provider Billing Via Terminal or Equivalent

If the provider bills via remote terminal with on-site (in the provider) editing or if the carrier or FI otherwise can communicate edit results to it electronically, the carrier or FI establishes a control record when the bill passes its consistency edits.

B. Manual Hardcopy Claim/Bills and Electronic Claim/Bills

The carrier or FI establishes a control record when it enters the initial claim into its system. The claim is counted for administering timely billing and payment only if it passes carrier or FI edits to the extent a pending record can be established. The date

received is the date the carrier or FI received the claim properly completed, passing all carrier or FI edits, even if entered into its system on a later date.

C. Bills Returned to Provider

If the carrier or FI returns the bill and retains a claim record to minimize data entry cost when returned, the receipt date is corrected when the bill is properly completed and passes carrier or FI edits.

D. Bills Requiring Medical Information

When a carrier or FI requests medical documentation, it retains the bill as a pending record until it either pays, denies, or rejects (in the case of FIs) it. Returning cases for review by the PRO is not a request for medical documentation. Claims that fail initial carrier or FI edits because required medical reports or other required attachments are not included are also not requests for medical documentation.

E. Adjustment and Cancel Bills

An adjustment request bill is a correction to a claim previously processed. The carrier or FI establishes a control record for it.

The carrier or FI counts adjustments as received and pending only when they pass carrier or FI edits. The carrier or FI assigns the date received in its mailroom as the receipt date for hospital and MSP adjustment requests.

The carrier or FI counts adjustment bills as processed when no further action by it is required. The final action taken on the adjustment request bill depends upon the situation.

80.2 - Definition of Clean Claim

(Rev. 1, 10-01-03)

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

A "clean" claim is one that does not require the carrier or FI to investigate or develop external to their Medicare operation on a prepayment basis. Clean claims must be filed in the timely filing period.

The following bullets are some examples of what are considered clean claims:

- Pass all edits (contractor and Common Working File (CWF)) and are processed electronically);
- Not require external development (i.e., are investigated within the claims, medical review, or payment office without the need to contact the provider, the beneficiary, or other outside source) (Note: these claims are not included in CPE scoring).
- Claims not approved for payment by CWF within 7 days of the FI's original claim submittal for reasons beyond the carrier's, FI's or provider's control (e.g., CWF system/communication difficulties);
- CWF out-of-service area (OSA) claims. These are claims where the beneficiary is not on the CWF host and CWF has to locate and identify where the beneficiary record resides;

- Claims subject to medical review but complete medical evidence is attached by the provider or forwarded simultaneously with EMC records in accordance with the carrier's or FI's instructions;
- Are developed on a postpayment basis; and,
- Have all basic information necessary to adjudicate the claim, and all required supporting documentation
-

80.2.1 - Receipt Date

(Rev. 273, Issued 08-13-04, Effective: 07-01-04, Implementation: 07-06-04)
A3-3600.1-Item 7

The receipt date of a claim is the date the contractor receives the claim (provided the filing is in a format and contains data sufficiently complete so that the filing qualifies as a claim). The receipt date is used to: determine if the claim was timely filed (see §70.3), determine the "payment floor" for the claim (see §80.2.1.2), determine the "payment ceiling" on the claim (see §80.2.1.1) and, when applicable, to calculate interest payment due for a clean claim that is not timely processed, and to report to CMS statistical data on claims, such as in workload reports.

A paper claim that is received by 5:00 p.m. on a business day, or by closing time if the contractor routinely ends its public business day between 4:00 p.m. and 5:00 p.m., must be considered as received on that date, even if the contractor does not open the envelope which contains the claim or does not enter the claims data into the claims processing system until a later date. A paper claim that is received after 5:00 p.m., or after the contractor's routine close of business between 4:00 p.m. and 5:00 p.m., is considered as received on the next business day.

A paper claim is considered as received if it is delivered to the contractor's place of business by the U.S. Postal Service, picked up from a P.O. box, or is otherwise delivered to the contractor's place of business by its routine close of business time. If the contractor uses a P.O. box for receipt of mailed claims, it must have its mail picked up from its box at least once per business day unless precluded on a particular day by the emergency closing of its place of business or that of its postal box site.

As electronic claim tapes and diskettes that may be submitted by providers or their agents to an FI are also subject to manual delivery, rather than direct electronic transmission, the paper claim receipt rule also applies to establish the date of receipt of claims submitted on such manually delivered tapes and diskettes.

Electronic claims transmitted directly to a contractor, or to a clearinghouse with which the contractor contracts as its representative for the receipt of its claims, by 5:00 p.m. in the contractor's time zone, or by its closing time if it routinely closes between 4:00 p.m. and 5:00 p.m., must likewise be considered as received on that day even if the contractor does not upload or process the data until a later date. **NOTE:** The differentiation between HIPAA-compliant and HIPAA-non-compliant electronic claims that is specified in §80.2.1.2 with respect to applying the payment floor, does not apply to establishing date of receipt. Use the methodology described above to establish the date of receipt for all electronic claims.

Paper and electronic claims that do not meet the basic legibility, format, or completion requirements are not considered as received for claims processing and may be rejected from the claims processing system. Rejected claims are not considered as received until resubmitted as corrected, complete claims. The contractor may not use the data entry date, the date of passage of front-end edits, the date the document control number is assigned, or any date other than the actual calendar date of receipt as described above to establish the official receipt date of a claim.

The following permissive exception applies to establishment of receipt date: Where its system or hours of operation permit, a contractor may, at its option, classify a paper or electronic claim received between its closing time and midnight, or on a Saturday, Sunday, holiday, or during an emergency closing period as received on the actual calendar date of delivery or receipt. Unless a contractor closes its place of business early in an isolated situation due to an emergency, the contractor's cutoff time for establishing the receipt date may never be earlier than 4:00 p.m.

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

The cutoff time for paper claims may not exceed the cutoff time for electronic claims. However, the cutoff time for electronic claims may exceed the cutoff time for paper claims and, indeed, carriers and FIs are encouraged to use this tool where their system and overnight batch run schedules permit. Likewise, at a carrier or FI's option, it may consider electronic claims received on a weekend or holiday as received on the actual calendar date of receipt, even though paper claims received in a P.O. box on a weekend or holiday would not be considered received until the next business day.

Where a carrier or FI prepares bills for payment for purchased DME because the $50 tolerance is exceeded (see §40.4.1) it establishes any date consistent with its system processing requirements as the receipt date for the second and succeeding bills. It uses the date as close to its payment as possible.

80.2.1.1 - Payment Ceiling Standards

(Rev. 454, Issued: 01-28-05, Effective: 04-01-05, Implementation: 04-04-05)

Payment ceilings were implemented for clean claims received by the carrier or FI on or after April 1, 1987. "Clean" claims must be paid or denied within the applicable number of days from their receipt date as follows:

Time Period for Claims Received	Applicable Number of Calendar Days
01-01-93 through 09-30-93	24 for EMC and 27 for paper claims
10-01-93 and later	30

All claims (i.e., paid claims, partial and complete denials, no payment bills) including PIP and EMC claims are subject to the above requirements.

Interest must be paid on claims that are not paid within the ceiling period.

The count starts on the day after the receipt date and it ends on the date payment is made. For example, for clean claims received October 1, 1993, and later, if this span is 30 days or less, the requirement is met.

The RAPs submitted by home health agencies under the HH PPS (records with type of bill 322 or 332 and dates of service on or after October 1, 2000) are not Medicare claims as defined under the Social Security Act. Since they are not considered claims, they (records with type of bill 322 or 332 and dates of service on or after October 1, 2000) are not subjected to payment ceiling standards and interest payment.
See Chapter 24, § 30.2 for definitions of electronic and paper claims for use in application of the Medicare payment floor. See Chapter 1, § 80.2.1.2 for differentiation between electronic claims that comply with the requirements of the standard implementation guides adopted for national use under HIPAA and those submitted electronically using pre-HIPAA formats supported by Medicare. This HIPAA format differentiation applies to the payment floor, but not to the ceiling.

80.2.1.2 - Payment Floor Standards

(Rev. 1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

The "payment floor" establishes a waiting period during which time the contractor may not pay, issue, mail, or otherwise finalize the initial determination on a clean claim. The "payment floor date" is the earliest day after receipt of the clean claim that payment may be made.

The payment floor date is determined by counting the number of days since the day the claim was received, i.e., the count begins the day after the day of receipt.

There are different waiting periods, and thus different payment floor dates, for electronic claims and paper claims. The waiting periods are 13 days for electronic claims and 26 days for paper claims. For the purpose of implementing the payment floor, the following definitions apply:

An "electronic claim" is a claim submitted via central processing unit (CPU) to CPU transmission, tape, direct data entry, direct wire, or personal computer upload or download. A claim that is submitted via digital FAX/OCR, diskette, or touch-tone telephone is not considered as an electronic claim.

A "paper claim" is submitted and received on paper, including fax print-outs. This also includes a claim that the contractor receives on paper and then reads electronically with OCR technology.

Also, for the purpose of implementing the payment floor, effective 7/1/04 and for the duration of the HIPAA contingency plan implementation, an electronic claim that does not conform to the requirements of the standard implementation guides adopted for national use under HIPAA, including electronic claims submitted electronically using pre-HIPAA formats supported by Medicare, is considered to be a paper claim.

Based on the waiting periods, the payment floor dates are as follows:

Claim Receipt Date	Payment Floor Date

10-01-93 through 6/30/04	14th day for EMC 27th day for paper claims
07-01-04 and later	14th day for HIPAA-compliant EMC 27th day for paper and non-HIPAA EMC
01/01/2006 and later	29th day for paper

Except as noted below, the payment floor applies to all claims. The payment floor does not apply to: "no-payment claims, RAPs submitted by Home Health Agencies, and claims for PIP payments.

NOTE: The basis for treating a non-HIPAA-compliant electronic claim as a paper claim for the purpose of determining the applicable payment floor is as follows: Effective October 16, 2003, HIPAA requires that claims submitted to Medicare electronically comply with standard claim implementation guides adopted for national use under HIPAA. A claim submitted via direct data entry (DDE), if DDE is supported by the contractor is considered to be a HIPAA-compliant electronic claim. A contingency plan has been approved to enable claims to continue to be submitted temporarily after October 15, 2003 in a pre-HIPAA electronic format supported by Medicare. Effective July 1, 2004, the Medicare contingency plan is being modified to encourage migration to HIPAA formats. Effective July 1, 2004, for purposes of the payment floor, only those claims submitted in a HIPAA-compliant format will be paid as early as the 14th day after the date of receipt. Claims submitted on paper after July 1, 2004 will not be eligible for payment earlier than the 27th day after the date of receipt. All claims subject to the 27-day payment floor, including non-HIPAA electronically submitted claims, are to be reported in the paper claims category for workload reporting purposes. Effective January 1, 2006, paper claims will not be eligible for payment earlier than the 29th day after the date of receipt.

This differentiation in treatment of HIPAA-compliant and non-HIPAA-compliant electronic claims does not apply to Contractor Performance Evaluation (CPE) reviews of carriers and FIs conducted by CMS. For CPE purposes, carriers and FIs must continue to process the CPE specified percentage of clean paper and clean electronic (HIPAA or non-HIPAA) claims within the statutorily specified timeframes. Effective for claims received January 1, 2006 and later, clean paper claims will no longer be included in CPE scoring for claims processing timeliness.

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

(Rev. 1771, Issued: 07-17-09, Effective: 08-17-09, Implementation: 08-17-09)

Interest must be paid on clean claims if payment is not made within the applicable number of calendar days (i.e., 30 days) after the date of receipt as described above. The applicable number of days is also known as the payment ceiling. For example, a clean claim received on March 1, 2009, must have been paid before the end of business on March 31, 2009. Interest is not paid on:

- Claims requiring external investigation or development by the provider's FI or carrier;
- Claims on which no payment is due;
- Full denials;
- Claims for which the provider is receiving PIP; or
- HH PPS RAPs

Interest is paid at the rate used for §3902(a) of title 3l, U.S. Code (relating to interest penalties for failure to make prompt payments). The interest rate is determined by the applicable rate on the day of payment.

This rate is determined by the Treasury Department on a 6-month basis, effective every January and July 1. Providers may access the Treasury Department Web page http://fms.treas.gov/prompt/rates.html for the correct rate. Medicare contractors shall include notification to providers of any change to the Treasury Department interest rate in their routine educational materials and/or website for providers.

Interest is calculated using the following formula:

Payment amount x rate x days divided by 365 (366 in a leap year) = interest payment

The interest period begins on the day after payment is due and ends on the day of payment.

NOTE: The example below is for one 6-month period in which the interest rate was 5.625 percent.

Milestones	**Clean Paper Claim (in calendar days)**	**Clean Electronic Claim (in calendar days)**
Date Received	March 1, 2009	March 1, 2009
Payment Due	March 31, 2009	March 31, 2009
Payment Made	April 3, 2009	April 3, 2009
Interest Begins	April 1, 2009	April 1, 2009
Days for Which Interest is Due	3	3
Amount of Payment	$100	$100
Interest Rate	5.625%	5.625%

See section 80.2.1.1 for the definition of EMC and paper claims.

The following formula is used:

For the clean paper claim - $100 X .05625 X 3 divided by 365 = $.0462 or $.05 when rounded to the nearest penny.

For the clean electronic claim - $100 X .05625 X 3 divided by 365 = $.0462 or $.05 when rounded to the nearest penny.

When interest payments are applicable, the Medicare contractor reports the amount of interest on each claim on the remittance record to the provider.

PIP/Non-PIP:

Under the periodic interim payment ("PIP") mechanism, a provider receives flat biweekly payments to approximate the average costs of covered inpatient services during a 2-week period. Non-PIP claims are claims made by a provider not under the periodic interim payment mechanism. PIP on inpatient bills does not preclude interest payments on outpatient bills. Interest is paid on a per bill basis at the time of payment.

80.2.2.1 - Determining and Paying Interest
(Rev. 273, Issued 08-13-04, Effective: 07-01-04, Implementation: 07-06-04)

The contractor must pay interest on clean, non-PIP (FIs) claims for which it does not make payment within the payment ceiling specified in § 80.2.1.1, provided payment is due on such claim. The interest rate and formula for calculation are shown above. The interest rate is determined by the rate applicable on the carrier or FI's payment date.

The contractor applies interest to the net payment amount after all applicable deductions are determined (e.g., deductible, copayment, and/or MSP). Interest is rounded to the nearest penny.

A. Reporting Interest Payment on Remittance Record

See 100-22 for remittance advice completion instructions.

B. Payment Made to Beneficiary

If interest is paid on a claim for which payment is made directly to the beneficiary, the contractor adds the following messages on the beneficiary notice:

"Your payment includes interest since we were unable to process your claim timely."

C. Claims Paid Upon Appeal

Interest payments are not payable on clean claims initially processed to denial and on which payment is made subsequent to the initial decision as a result of an appeal request. This applies to appeals where more than the applicable number of days elapsed before an

initial denial, but the claim was later paid upon appeal. Where an appeal of a previously paid claim results in increased payment FIs follow the following section.

D. Interest on Postpayment Denials and Other Adjustments

If a paid claim is later denied in full, the carrier or FI recovers any interest paid as well as the incorrect payment. It does not pay interest on the related no payment bill. If the claim is partially denied, interest is payable on the reduced amount. The FI recalculates the interest due based upon the new reimbursement amount. It uses the rate of interest and elapsed days applicable to the original claim. This can be accomplished by applying a ratio of the new reimbursement amount (from its debit action) to the reimbursement amount on the initial claim (from its credit action). It multiplies the result by the interest amount paid on the initial claim. The result is the interest amount payable on its debit action. The following formula is used to calculate interest:

$$\text{Interest} = \frac{\text{Debit action reimbursement amount}}{\text{Credit action reimbursement amount}} \times \text{original interest paid}$$

Use of the formula is preferable to expanding an FI system to handle multiple scheduled payment dates and calculation procedures.

80.2.2.2 - Preparation of IRS Form 1099-INT
(Rev. 1, 10-01-03)

The IRS requires that interest paid in the course of a "trade or business" be reported if it totals at least $600 for any person. Interest payments a carrier or FI makes fall within the "trade or business" definition. Therefore, FIs and carriers must prepare and file with the IRS, Form 1099-INT when interest payments for a calendar year to a beneficiary or provider total at least $600. The carrier or FI uses the beneficiary's individual Social Security Number (SSN) to report interest paid to the beneficiary. Individual SSNs are identified by the suffix A or M, J, T, or TA. Other suffixes mean benefits are based upon a spouse's, parent's or child's (F1 thru 8) SSN. If the spouse's, parent's or child's SSN is involved, the FI determines the individual's SSN to report interest. If the individual's SSN is not present, the carrier or FI calls its Social Security Office contact for the information.

80.3 - Other Claims (other than clean)
(Rev. 1, 10-01-03)
A3-3600.1 Item 4, HO-401.E, B2-5240.11.B

Claims that do not meet the definition of "clean" claims are "other" claims. "Other" claims require investigation or development external to the carrier or FI's Medicare operation on a prepayment basis. "Other" claims are those that are not approved by CWF for payment that the FI identifies as requiring outside development. Examples are claims on which the provider's FI/carrier:

- Requests additional information from the provider or another external source. This includes routine data omitted from the bill, medical information, or information to resolve discrepancies;

- Requests information or assistance from another contractor. This includes requests for charge data from the carrier, or any other request for information from the carrier;

- Develops Medicare Secondary Payer (MSP) information;

- Requests information necessary for a coverage determination;

- Performs sequential processing when an earlier claim is in development; and

- Performs outside development as a result of a CWF edit.

80.3.1 - Incomplete or Invalid Claims Processing Terminology
(Rev. 1588; Issued: 09-05-08; Effective/Implementation Date: 08-18-08)

The following definitions apply to §80.3.2. For carriers the requirements apply to Part B assigned and unassigned claims (Form CMS-1500) or electronic data interchange equivalent.

Unprocessable Claim - Any claim with incomplete or missing, required information, or any claim that contains complete and necessary information; however, the information provided is invalid. Such information may either be required for all claims or required conditionally.

Incomplete Information - Missing, required or conditional information on a claim (e.g., no Unique Physician Identification Number (UPIN) / Provider Identification Number (PIN) or National Provider Identifier (NPI) when effective).

Invalid Information - Complete required or conditional information on a claim that is illogical, or incorrect (e.g., incorrect UPIN/PIN or NPI when effective), or no longer in effect (e.g., an expired number).

Required - Any data element that is needed in order to process a claim (e.g., Provider Name, Date of Service).

Not Required - Any data element that is optional or is not needed by Medicare in order to process a claim (e.g., Patient's Marital Status).

Conditional - Any data element that must be completed if other conditions exist (e.g., if there is insurance primary to Medicare, then the primary insurer's group name and number must be entered on a claim or if the insured is different from the patient, then the insured's name must be entered on a claim).

Return as Unprocessable or Return to Provider (RTP)- Returning a claim as unprocessable to the provider (RTP) does not mean that the carrier or FI should physically return every claim it received with incomplete or invalid information. The term “return to provider” is used to refer to the many processes utilized today for notifying the provider or supplier of service that their claim cannot be processed, and that it must be corrected or resubmitted. Some (not all) of the various techniques for returning claims as unprocessable include:

- Incomplete or invalid information is detected at the front-end of the carrier or FI claims processing system. The claim is returned to the provider (RTP’d) either electronically or in a hardcopy/checklist type form explaining the error(s) and how to correct the errors prior to resubmission. Claim data are not retained in the system for these RTP'd claims. No RA is issued.

- Incomplete or invalid information is detected at the front-end of the claims processing system and is suspended and developed. If requested corrections and/or medical documentation are submitted within a 45-day period, the claim is processed. Otherwise, the suspended portion is returned and the supplier or provider of service is notified by means of the RA.

- Incomplete or invalid information is detected within the claims processing system and is rejected through the remittance process. Suppliers or providers of service are notified of any error(s) through the remittance notice and how to correct prior to resubmission. A record of the claim is retained in the system (**NOTE:** This applies to carriers only. FIs do not use the remittance advice process for return to provider (RTP)).

A claim returned as unprocessable for incomplete or invalid information does not meet the criteria to be considered as a claim, is not denied, and, as such, is not afforded appeal rights.

80.3.2 - Handling Incomplete or Invalid Claims

(Rev.: 4388; Issued: 09-06-19; Effective: 10-07-19; Implementation: 10-07-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary’s Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

Claims processing specifications describe whether a data element is required, not required, or conditional (a data element which is required when certain conditions exist). The status of these data elements will affect whether or not an incomplete or invalid claim (hardcopy or electronic) will be "returned as unprocessable" by the A/B MAC (B)

or "returned to provider" (RTP) by the A/B MAC (A). The contractor shall not deny claims and afford appeal rights for incomplete or invalid information as specified in this instruction. (See §80.3.1 for Definitions.)

If a data element is required and it is not accurately entered in the appropriate field, the contractor returns the claim to the provider of service.

- If a data element is required, or is conditional (a data element that is required when certain conditions exist) and the conditions of use apply) and is missing or not accurately entered in its appropriate field, the contractor shall return as unprocessable or RTP the claim to either the supplier or provider of service.

NOTE: Effective for claims with dates of service (DOS) on or after the implementation date of the ordering and referring phase 2 edits, Part B clinical lab and imaging technical or global component claims, Durable Medical Equipment, Prosthetics, claims and Home Health Agency (HHA) claims shall be denied, in accordance with CMS-6010-F final rule published on April 24, 2012, if the ordering or referring provider's information is invalid or if the provider is not of a specialty that is eligible to order and refer.

- If a claim must be returned as unprocessable or RTP for incomplete or invalid information, the contractor shall, at minimum, notify the provider of service of the following information:

    - Beneficiary's Name;
    - Medicare beneficiary identifier;
    - Dates of Service (MMDDCCYY) (Eight-digit date format effective as of October 1, 1998);
    - Patient Account or Control Number (only if submitted);
    - Medical Record Number (FIs only, if submitted); and
    - Explanation of Errors (e.g., Remittance Advice Reason and Remark Codes)

NOTE: Some of the information listed above may in fact be the information missing from the claim. If this occurs, the contractor includes what is available.

Depending upon the means of return of a claim, the supplier or provider of service has various options for correcting claims returned as unprocessable or RTP for incomplete or invalid information. They may submit corrections either in writing, on-line, or via telephone when the claim was suspended for development, or submit as a "corrected" claim or as an entirely new claim if data from the original claim was not retained in the system, as with a front-end return, or if a remittance advice was used to return the claim.

The chosen mode of submission, however, must be currently supported and appropriate with the action taken on the claim.

NOTE: The supplier or provider of service must not be denied any services (e.g., modes of submission or customer service), other than a review, to which they would ordinarily have access.

- If a claim or a portion of a claim is "returned as unprocessable" or RTP for incomplete or invalid information, the contractor does not generate an MSN to the beneficiary.

- The notice to the provider or supplier will not contain the usual reconsideration notice, but will show each applicable error code or equivalent message.

- If the contractor uses an electronic or paper remittance advice notice to return an unprocessable claim, or a portion of unprocessable claim:

1. The remittance advice must demonstrate all applicable error codes. At a minimum there must be a CARC/RARC combination that is compliant with CAQH CORE Business Scenario Two.

2. The returned claim or portion must be stored and annotated, as such, in history, if applicable. If contractors choose to suspend and develop claims, a mechanism must be in place where the contractor can re-activate the claim or portion for final adjudication.

A. Special Considerations

- If a "suspense" system is used for incomplete or invalid claims, the contractor will not deny the claim with appeal rights if corrections are not received within the suspense period, or if corrections are inaccurate. The contractor must return the unprocessable claim, without offering appeal rights, to the provider of service or supplier.

For assigned and unassigned claims submitted by beneficiaries (Form CMS-1490S), that are incomplete or contain invalid information, contractors shall manually return the claims to the beneficiaries. If the beneficiary furnishes all other information but fails to supply the provider or supplier's NPI, and the contractor can determine the NPI using the NPI registry, the contractor shall continue to process and adjudicate the claim. If the contractor determines that the provider or supplier was not a Medicare enrolled provider with a valid NPI, the contractor shall follow previously established procedures in order to process and adjudicate the claim.

Contractors shall send a letter to the beneficiary with information explaining which information is missing, incorrect or invalid; information explaining the mandatory claims filing requirements; instructions for resubmitting the claim if the provider or supplier refuses to file the claim, or enroll in Medicare, and shall include language encouraging

the beneficiary to seek non-emergency care from a provider or supplier that is enrolled in the Medicare program. Contractors shall also notify the provider or supplier about his/her obligation to submit claims on behalf of Medicare beneficiaries and that providers and suppliers are required to enroll in the Medicare program to receive reimbursement.

Contractors shall consider a complete claim to have all items on the Form CMS-1490S completed along with an itemized bill with the following information: date of service, place of service, description of each surgical or medical service or supply furnished; charge for each service; treating doctor's or supplier's name and address; diagnosis code; procedure code and the provider or supplier's NPI. The ordering & referring provider's legal name and address and the National Provider Identifier (NPI) if known must be included on the itemized bill if from a Clinical laboratory for ordered tests; an independent diagnostic imaging center for ordered imaging procedures or a supplier of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) for ordered DMEPOS. Required information on a claim must be valid for the claim to be considered as complete.

If a beneficiary submits a claim on the Form CMS-1500, return the Form CMS-1500 claim to the beneficiary, and include a copy of the Form CMS-1490S, along with a letter instructing the beneficiary to complete and return the Form CMS-1490S for processing within the time period prescribed in §70.5 above. Include in the letter a description of missing, invalid or incomplete items required for the Form CMS-1490S that were not included with the submitted Form CMS-1500 or were invalid.

NOTE: Telephone inquiries are encouraged.

- Contractors shall not return an unprocessable claim if the appropriate information for both "required" and "conditional" data element requirements other than an NPI when the NPI is effective is missing or inaccurate but can be supplied through internal files. Contractors shall not search their internal files to correct missing or inaccurate "required" and "conditional" data elements required under Sections 80.3.2.1.1 through 80.3.2.1.3 and required for HIPAA compliance for claims governed by HIPAA.

- For either a paper or electronic claim, if all "required" and "conditional" claim level information that applies is complete and entered accurately, but there are both "clean" and "dirty" service line items, then split the claim and process the "clean" service line item(s) to payment and return as unprocessable the "dirty" service line item(s) to the provider of service or supplier**. NOTE:** This requirement applies to carriers only.

No workload count will be granted for the "dirty" service line portion of the claim returned as unprocessable. The "clean" service line portion of the claim may be counted as workload **only if it is processed through the remittance process**. Contractors must abide by the specifications written in the above instruction; return the "dirty" service line portion without offering appeal rights.

- Workload will be counted for claims returned as unprocessable through the remittance process. Under no circumstances should claims returned as unprocessable by means other than the remittance process (e.g., claims returned in the front-end) be reported in the workload reports submitted to CMS. The contractor is also prohibited from moving or changing the action on an edit that will result in an unprocessable claim being returned through the remittance process. If the current action on an edit is to suspend and develop, reject in the front or back-end, or return in the mailroom, the contractor must continue to do so. Workload is only being granted to accommodate those who have edits which currently result in a denial. As a result, workload reports should not deviate significantly from those reports prior to this instruction.

NOTE: Rejected claims are not counted as an appeal on resubmissions.

B. Special Reporting of Unprocessable Claims Rejected through the Remittance Process (Carriers Only):

A/B MACs (B) must report "claims returned as unprocessable on a remittance advice" on line 15 (Total Claims Processed) and on line 14 (subcategory Non-CWF Claims Denied) of page one of your Form CMS-1565. Although these claims are technically not denials, line 14 is the only suitable place to report them given the other alternatives. In addition, these claims should be reported as processed "not paid other" claims on the appropriate pages (pages 2-9) of CROWD Form T for the reporting month in which the claims were returned as unprocessable through the remittance process. Also, A/B MACs (B) report such claims on Form Y of the Contractor Reporting of Operational and Workload Data (CROWD) system. They report the "number of such claims returned during the month as unprocessable through the remittance process" under Column 1 of Form Y on a line using code "0003" as the identifier.

If a supplier, physician, or other practitioner chooses to provide missing or invalid information for a suspended claim by means of a telephone call or in writing (instead of submitting a new or corrected claim), A/B MACs (B) do not report this activity as a claim processed on Form CMS-1565/1566. Instead, they subtract one claim count from line 3 of Form Y for the month in which this activity occurred.

EXAMPLE: Assume in the month of October 2001 the carrier returned to providers 100 claims as unprocessable on remittance advices. The carrier should have included these 100 claims in lines 14 and 15 of page 1 of your October 2001 Form CMS-1565. During this same month, assume the carrier received new or corrected claims for 80 of the 100 claims returned during the month. These 80 claims should have been counted as claims received in line 4 of your October 2001 Form CMS-1565 page one (and subsequently as processed claims for the reporting month when final determination was made).

Also, during October 2001, in lieu of a corrected claim from providers, assume the carrier received missing information by means of a telephone call or in writing for 5 out of the

100 claims returned during October 2001. This activity should not have been reported as new claims received (or subsequently as claims processed when adjustments are made) on Form CMS-1565. On line 3 of Form Y for October 2001, the A/B MAC (B) should have reported the number 95 (From claims returned as unprocessable through the remittance process minus 5 claims for which the carrier received missing or invalid information by means of a telephone call or in writing.

For the remaining 15 claims returned during October 2001 with no response from providers in that same month, the carrier should have reported on the Form CMS-1565 or Form Y, as appropriate, any subsequent activity in the reporting month that it occurred. For any of these returned claims submitted as new or corrected claims, the A/B MAC (B) should have reported their number as receipts on line 4 of page one of Form CMS-1565. For any of these returned claims where the supplier or provider of service chose to supply missing or invalid information by means of a telephone call or in writing, the A/B MAC (B) should not have counted them again on Form CMS-1565, but subtracted them from the count of returned claims reported on line 3 of Form Y for the month this activity occurred.

C. Exceptions (A/B MACs (B) Only)

The following lists some exceptions when a claim may not be "returned as unprocessable" for incomplete or invalid information.

A/B MACs (B) shall not return a claim as unprocessable:

If a patient, individual, physician, supplier, or authorized person's signature is missing, but the signature is on file, or if the applicable signature requirements have been met, do not return a claim as unprocessable where an authorization is attached to the claim or if the signature field has any of the following statements (unless an appropriate validity edit fails):

Acceptable Statements for Form CMS-1500:

- For items 12, 13, and 31, "Signature on File" statement and/or a computer generated signature;

- For items 12 and 13, Beneficiary's Name "By" Representative's Signature;

For item 12, "X" with a witnessed name and address. (Chapter 26 for instructions.)

D. Misdirected Claims

See §10.1.9 for instructions on handling claims that are submitted to the wrong contractor, or to the wrong payment jurisdiction.

80.3.2.1.1 - A/B MAC (B) Data Element Requirements

(Rev. 4201, Issued: 01-18-19, Effective: 02-19-19, Implementation: 02-19-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

A - Required Data Element Requirements

1 - Paper Claims

The following instruction describes certain data element formatting requirements to be followed when reporting the calendar year date for the identified items on the Form CMS-1500:

- If birth dates are furnished in the items stipulated below, then these items must contain 8-digit birth dates (MMDDCCYY). This includes 2-digit months (MM) and days (DD), and 4-digit years (CCYY).

Form CMS-1500 Items Affected by These Reporting Requirements:

Item 3 - Patient's Birth Date

Item 9b - Other Insured's Date of Birth

Item 11a - Insured's Date of Birth

Note that 8-digit birth dates, when provided, must be reported with a space between month, day, and year (i.e., MM_DD_CCYY). On the Form CMS-1500, the space between month, day, and year is delineated by a dotted, vertical line.

If a birth date is provided in items 3, 9b, or 11a, and is not in 8-digit format, carriers must return the claim as unprocessable.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.

Group Code: CO
CARC: 16
RARC: N329
MSN: N/A

If carriers do not currently edit for birth date items because they obtain the information from other sources, they are not required to return these claims if a birth date is reported

in items 3, 9b, or 11a. and the birth date is not in 8-digit format. However, if carriers use date of birth information on the incoming claim for processing, they must edit and return claims that contain birth date(s) in any of these items that are not in 8-digit format.

For certain other Form CMS-1500 conditional or required date items (items 11b, 14, 16, 18, 19, or 24A.), when dates are provided, either a 6-digit date or 8-digit date may be provided.

If 8-digit dates are furnished for any of items 11a., 14, 16, 18, 19, or 24A. (excluding items 12 and 31), carriers must note the following:

- All completed date items, except item 24A., must be reported with a space between month, day, and year (i.e., MM_DD_CCYY). On the Form CMS-1500, the space between month, day, and year is delineated by a dotted, vertical line;

- Item 24A. must be reported as one continuous number (i.e., MMDDCCYY), without any spaces between month, day, and year. By entering a continuous number, the date(s) in item 24A. will penetrate the dotted, vertical lines used to separate month, day, and year. Carrier claims processing systems will be able to process the claim if the date penetrates these vertical lines. However, all 8-digit dates reported must stay within the confines of item 24A;

- Do not compress or change the font of the "year" item in item 24A. to keep the date within the confines of item 24A. If a continuous number is furnished in item 24A. with no spaces between month, day, and year, you will not need to compress the "year" item to remain within the confines of item 24A.;

- The "from" date in item 24A. must not run into the "to" date item, and the "to" date must not run into item 24B.;

- Dates reported in item 24A. must not be reported with a slash between month, day, and year; and

- If the provider of service or supplier decides to enter 8-digit dates for any of items 11b, 14, 16, 18, 19, or 24A. (excluding items 12 and 31), an 8-digit date must be furnished for all completed items. For instance, you cannot enter 8-digit dates for items 11b, 14, 16, 18, 19 (excluding items 12 or 31), and a 6-digit date for item 24A. The same applies to those who wish to submit 6-digit dates for any of these items.

A/B MACs (B) must return claims as unprocessable if they do not adhere to these requirements.

2 - Electronic Claims

A/B MACs (B) must return all electronic claims that do not include an 8-digit birth date (CCYYMMDD) when a date is reported.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.

Group Code: CO
CARC: 16
RARC: N329
MSN: N/A

If A/B MACs (B) do not currently edit for birth date items because they obtain the information from other sources, they are not required to return these claims if a birth date is reported in items 3, 9b., or 11a. and the birth date is not in 8-digit format. However, if A/B MACs (B) do use date of birth information on the incoming claim for processing, they must edit and return claims that contain birth date(s) in any of these items that are not in 8-digit format.

B - Required Data Element Requirements

The following Medicare-specific, return as unprocessable requirements in this section and the following two sections are in addition to requirements established under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Regulations implementing HIPAA require the use of National Provider Identifiers (NPIs) by covered health care providers and health plans. Although not required by HIPAA, CMS is extending the requirement to include the NPI on electronic claims to paper claims submitted on the Form CMS-1500. A/B MACs (B) are referred to the Health Care Claims Professional 837 Implementation guide for requirements for professional claims subject to HIPAA, including the NPI reporting requirements.

A/B MACs (B) must return a claim as unprocessable to a provider of service or supplier and use the indicated remittance advice codes.

Carriers shall return a claim as unprocessable:

1. If a claim lacks a valid Medicare beneficiary identifier in item 1a. or contains an invalid Medicare beneficiary identifier in item 1a.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.

Group Code: CO
CARC: 16
RARC: N382

MSN: N/A

80.3.2.1.2 - Conditional Data Element Requirements for A/B MACs and DME MACs

(Rev. 4473, Issued: 12-6-19; Effective: 3-9-20; Implementation: 3-9-20)

A - Universal Requirements

The following instruction describes "conditional" data element requirements, which are applicable to certain assigned A/B MAC (B) claims. This instruction is minimal and does not include all "conditional" data element requirements, which are universal for processing claims.

Items from the Form CMS-1500 claim form have been provided. These items are referred to as fields in the instruction.

A/B MACs (B) processing claims on the Form CMS-1500 shall return a claim as unprocessable to the supplier/provider of service in the following circumstances:

1. If a service was ordered or referred by a physician, physician assistant, nurse practitioner, or clinical nurse specialist (other than those services specified in Claim Specific Requirements) and his/her name is not present in item 17 or if the NPI is not entered in item 17b of the Form CMS-1500.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.

Group Code: CO
CARC: 16
RARC: N285 (for missing name) or N286 (for missing identifier)
MSN: N/A

2. If a physician extender or other limited licensed practitioner refers a patient for consultative services, but the name and/or NPI required of the supervising physician is not entered in items 17 or if the NPI is not entered in item 17b of the Form CMS-1500.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.

Group Code: CO
CARC: 16
RARC: N269 (for missing name) or N270 (for missing identifier)

MSN: N/A

NOTE: For item 80.3.2.1.2 -1 above, effective for claims with dates of service (DOS) on or after the implementation date of the Phase 2 ordering and referring denial edits, a Part B clinical lab and imaging technical or global component claim or Durable Medical Equipment, Prosthetics, and Orthotics Suppliers (DMEPOS) claim is denied when the ordering/referring provider not allowed to order/refer.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: CO
CARC: 183
RARC: N574, MA13
MSN: 21.6

The claim is denied when the first four letters of the last name provided on the ordering/referring provider's claim does not match what is listed in the provider's record.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.

Group Code: CO
CARC: 16
RARC: N264, MA13, N575
MSN: 21.6

If the claim is submitted that lists an ordering/referring provider and the required matching NPI is not reported, then the claim shall be rejected. This is the only instance when a rejection is allowed.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.

Group Code: CO
CARC: 16
RARC: N265, MA13
MSN: N/A

For 3 through 12 below, the contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under these

policies. These CARC/RARC combinations compliant with CAQH CORE Business Scenario Two.

Group Code: CO
CARC: 16
RARC: shown below.
MSN: N/A

3. For the technical component and professional component of diagnostic tests subject to the anti-markup payment limitation:

    a. If a "YES" or "NO" is not indicated in item 20 and no acquisition price is entered under the word "$CHARGES." A/B MACs (B) shall assume the service is not subject to the anti-markup payment limitation. This claim shall not be returned as unprocessable for this reason only.

    b. If a "Yes" or "No" is not indicated in item 20 and an acquisition price is entered under the word "$CHARGES." RARC: MA110

    c. If the "YES" box is checked in item 20 and a required acquisition price is not entered under the word "$CHARGES." RARC: MA111

    d. If the "NO" box is checked in item 20 and an acquisition price is entered under the word "$CHARGES." RARC: MA110

    e. If the "YES" box is checked in item 20 and the acquisition price is entered under "$CHARGES", but the performing physician or other supplier's name, address, ZIP Code, and NPI is not entered into item 32a of the Form CMS-1500 when billing for diagnostic services subject to the anti-markup payment limitation. RARC: N294

    Entries f – k are effective for claims received on or after April 1, 2004:

    f. On the Form CMS-1500, if the "YES" box is checked in Item 20, and more than one test is billed on the claim;

    g. On the Form CMS-1500, if both the technical component and professional component are billed on the same claim and the dates of service and places of service do not match;

    h. On the Form CMS-1500, if the "YES" box is checked in Item 20, both the technical component and professional component are submitted and the date of service and place of service codes do not match.

    i. On the ASC X12 837 professional claim format, if there is an indication on the claim that a test is subject to the anti-markup payment limitation, more

than one test is billed on the claim, and line level information for each total acquisition amount is not submitted for each test.

j. On the Form CMS-1500 if the "YES" box is checked in Item 20 and on the ASC X12 837 professional claim format if there is an indication on the claim that a test is subject to the anti-markup payment limitation, and the service is billed using a global code rather than having each component billed as a separate line item.

k. If there is an indication on the claim that the test is subject to anti-markup and the NPI of the performing entity (in Item 32a of the CMS-1500 or its ASC X12 837 equivalent) belongs to the billing provider OR the performing entity is not a valid, Medicare enrolled entity.

4. If a provider of service or supplier is required to submit a diagnosis in item 21 and either the diagnosis code is missing, incorrect or truncated; or a narrative diagnosis was not provided on an attachment. RARC: M76

5. For claims received on or after April 1, 2013, if a provider of service or supplier is required to submit a diagnosis in Item 21 of the Form CMS- 1500 and an ICD-9-CM "E" code (external causes of injury and poisoning) is reported in the first field of Item 21. And, effective for dates of service on or after the effective date for ICD-10-CM codes, if an ICD-10-CM diagnosis code within the code range of V00 through Y99 is reported in the first field of Item 21. RARC: MA63

   For paper claims, ICD-10-CM codes can be reported only on the revised CMS-1500 claim form version 02/12, but not before the effective date of ICD-10-CM. The revised form (02/12) has the capacity to accept either ICD-9-CM or ICD-10-CM codes depending upon the effective date of the ICD code set. The old form version (08/05) had only the capacity to accept ICD-9-CM codes. Refer to chapter 26 for more information about the old and revised forms).

6. If a rendering physician, physician assistant, nurse practitioner, clinical nurse specialist, supplier/or other practitioner who is a sole practitioner or is a member of a group practice does not enter his/her NPI into item 24J of Form CMS-1500 except for influenza virus and pneumococcal vaccine claims submitted on roster bills that do not require a rendering provider NPI. RARC: N290

7. If a primary insurer to Medicare is indicated in item 11, but items 4, 6, and 7 are incomplete. Item 4: RARC: MA92. Item 6: RARC: MA89. Item 7: RARC: MA88.

8. If there is insurance primary to Medicare that is indicated in item 11 by either an insured/group policy number or the Federal Employee Compensation Act number, but a Payer or Plan identification number (use HPID when effective) is not entered in field 11C (RARC: MA92), or the primary payer's program or plan name when a Payer or Plan ID (use HPID when effective) does not exist (RARC: N245).

9. If a HCPCS code modifier must be associated with a HCPCS procedure code or if the HCPCS code modifier is invalid or obsolete. RARC: M20

10. If a date of service extends more than 1 day and a valid "to" date is not present in item 24A. RARC: M59

11. If an "unlisted procedure code" or a "not otherwise classified" (NOC) code is indicated in item 24D, but an accompanying narrative is not present in item 19 or on an attachment. RARC: M51

12. If the name, address, and ZIP Code of the facility where the service was furnished in a hospital, clinic, laboratory, or facility other than the patient's home or physician's office is not entered in item 32 (Remark code MA114 is used.) Effective for claims received on or after April 1, 2004, the name, address, and ZIP Code of the service location for all services other than those furnished in place of service home – 12 must be entered. RARC: MA114

    Effective for claims with dates of service on or after October 1, 2007, the name, address, and 9-digit ZIP Code of the service location for services paid under the Medicare Physician Fee Schedule and anesthesia services, other than those furnished in place of service home – 12, and any other places of service A/B MACs treat as home, must be entered according to Pub. 100-04, Chapter 1, sections 10.1.1 and 10.1.1.1. RARC: MA114

    Effective for claims with dates of service on or after October 1, 2007, for claims received that require a 9-digit ZIP Code with a 4 digit extension, a 4-digit extension that matches one of the ZIP9 file or a 4-digit extension that can be verified according to Pub. 100-04, Chapter 1, sections 10.1.1 and 10.1.1.1 must be entered on the claim. RARC: MA114

    Effective January 1, 2011, for claims processed on or after January 1, 2011, on the Form CMS-1500, the name, address, and 5 or 9-digit ZIP code, as appropriate, of the location where the service was performed for services paid under the Medicare Physician Fee Schedule and anesthesia services, shall be entered according to Pub. 100-04, Chapter 1, sections 10.1.1 and 10.1.1.1 for services provided in all places of service. RARC: MA114

    Effective January 1, 2011, for claims processed on or after January 1, 2011, using the 5010 version of the ASC X12 837 professional electronic claim format for services payable under the MPFS and anesthesia services when rendered in POS home (or any POS they consider home) if submitted without the service facility location. RARC: MA114

13. Effective for claims received on or after April 1, 2004, if more than one name, address, and ZIP Code is entered on the Form CMS-1500 in item 32.

14. If any of the modifiers PA, PB, or PC are incorrectly associated with a service which is other than a wrong surgery on a patient, surgery on the wrong body part, surgery on the wrong patient or a service related to one of these surgical errors.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.

Group Code: CO
CARC: 4
RARC: N/A
MSN: N/A

80.3.2.1.3 - A/B MAC (B) Specific Requirements for Certain Specialties/Services

(Rev. 3510, Issued: 04-29-16, Effective: 10-01-16, Implementation; 10-03-16)

Unless otherwise specified, the contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under the policies in this section. These CARC/RARC combinations compliant with CAQH CORE Business Scenario Two.

Group Code: CO
CARC: 16
RARC: shown below.
MSN: N/A

A/B MACs (B) must return the following claim as unprocessable to the provider of service/supplier:

A. For chiropractor claims:

1. If the x-ray date is not entered in item 19 for claims with dates of service prior to January 1, 2000. Entry of an x-ray date is not required for claims with dates of service on or after January 1, 2000.

2. If the initial date "actual" treatment occurred is not entered in item 14. RARC: MA122

B. For certified registered nurse anesthetist (CRNA) and anesthesia assistant (AA) claims, if the CRNA or AA is employed by a group (such as a hospital, physician, or ASC) and the group's name, address, and ZIP Code is not entered in item 33 or if the NPI is not entered in item 33a of the Form CMS-1500, if their personal NPI is not entered in item 24J of the Form CMS-1500. RARC: MA112

C. For durable medical, orthotic, and prosthetic claims, if the name, address, and ZIP Code of the location where the order was accepted were not entered in item 32. RARC: MA114

D. For physicians who maintain dialysis patients and receive a monthly capitation payment:

1. If the physician is a member of a professional corporation, similar group, or clinic, and the NPI is not entered into item 24J of the Form CMS-1500. RARC: N290

2. If the name, address, and ZIP Code of the facility other than the patient's home or physician's office involved with the patient's maintenance of care and training is not entered in item 32. RARC: MA114. Effective for claims received on or after April 1, 2004, the name, address, and ZIP Code of the service location for all services other than those furnished in place of service home – 12 must be entered.

E. For routine foot care claims, if the date the patient was last seen (RARC: N324) and the attending physician's NPI is not present in item 19 (RARC: N253).

F. For immunosuppressive drug claims, if a referring/ordering physician, physician's assistant, nurse practitioner, clinical nurse specialist was used and their name is not present in items 17 or 17a. (RARC: N264), or if the NPI is not entered in item 17b. of the Form CMS-1500 (RARC: N286).

G. For all laboratory services, if the services of a referring/ordering physician, physician's assistant, nurse practitioner, clinical nurse specialist are used and his or her name is not present in items 17 or in 17a. (RARC: N264) or if the NPI is not entered in item 17b. of the Form CMS-1500 (RARC: N286).

H. For laboratory services performed by a participating hospital-leased laboratory or independent laboratory in a hospital, clinic, laboratory, or facility other the patient's home or physician's office (including services to a patient in an institution), if the name, address, and ZIP Code of the location where services were performed is not entered in item 32. RARC: MA114 Effective for claims received on or after April 1, 2004, the name, address, and ZIP Code of the service location for all services other than those furnished in place of service home – 12 must be entered.

I. For independent laboratory claims:

1. Involving EKG tracing and the procurement of specimen(s) from a patient at home or in an institution, if the claim does not contain a validation from the prescribing physician that any laboratory service(s) performed were conducted at home or in an institution by entering the appropriate annotation in item 19 (i.e., "Homebound"). RARC: MA116

2. If the name, address, and ZIP Code where the test was performed is not entered in item 32, if the services were performed in a location other than the patient's home or physician's office. RARC: MA114. Effective for claims received on or after April 1, 2004, the name, address, and ZIP Code of the service location for all services other than those furnished in place of service home – 12 must be entered.

3. When a diagnostic service is billed as an anti-markup service and the service is purchased from another billing jurisdiction, the billing physician or supplier must submit the name, address, and ZIP Code of the performing physician or supplier in Item 32, and the NPI of the performing physician or supplier in Item 32a. If Items 32 and 32a are not entered. RARC: MA114

J. For mammography "diagnostic" and "screening" claims, if a qualified screening center does not accurately enter their 6-digit, FDA-approved certification number in item 32 when billing the technical or global component. RARC: MA128

K. For parenteral and enteral nutrition claims, if the services of an ordering/referring physician, physician assistant, nurse practitioner, clinical nurse specialist are used and their name is not present in item 17 (RARC: N264) or if the NPI is not entered in item 17b. of the Form CMS-1500(RARC: N286).

L. For portable x-ray services claims, if the ordering physician, physician assistant, nurse practitioner, clinical nurse specialist's name, and/or NPI is not entered in items 17 (RARC: N264) or if the NPI is not entered in item 17b. of the Form CMS-1500 (RARC: N286).

M. For radiology and pathology claims for hospital inpatients, if the referring/ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist's name, if appropriate, is not entered in item 17 (RARC: N264) or if the NPI is not entered in item 17b. of the Form CMS-1500 (RARC: N286).

N. Effective for claims with dates of service on or after October 1, 2012, all claims for physical therapy, occupational therapy, or speech-language pathology services, including those furnished incident to a physician or nonphysician practitioner (NPP) services, must have the name and NPI of the certifying physician or NPP of the therapy plan of care. For the purposes of processing professional claims, the certifying physician/NPP is considered a referring provider. For paper billing, the certifying physician/NPP name and NPI is entered in Items 17 and 17b. Providers and suppliers filing electronic claims are required to comply with applicable HIPAA ASC X12 837 claim completion requirements for reporting a referring provider. (See Pub. 100-04, chapter 5, §20 and Pub. 100-02, chapter 15, §§220 and 230 for therapy service policies.)

NOTE: For items 80.3.2.1.3 (g), (k), (l), (m), and (n) above, effective for claims with dates of services (DOS) on or after the implementation date of the Phase 2 ordering and referring denial edits, the Part B clinical lab and imaging technical or global component

claim, or Durable Medical Equipment, Prosthetics, and Orthotics Suppliers (DMEPOS) claim is denied due to the ordering/referring provider not allowed to order/refer.

For item N only: The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: CO
CARC: 183
RARC: N574
MSN: N/A

The claim is denied when the first four letters of the last name provided on the ordering/referring provider's claim does not match what is listed in the provider's record.
RARC: N264

If the claim is submitted that lists an ordering/referring provider and the required matching NPI is not reported, then the claim shall be rejected. This is the only instance when a rejection is allowed. RARC: N256.

O. For all laboratory work performed outside a physician's office, if the claim does not contain a name, address, and ZIP Code for where the laboratory services were performed in item 32 or if the NPI is not entered into item 32a of the Form CMS-1500 if the services were performed at a location other than the place of service home – 12. RARC: MA114

P. For all physician office laboratory claims, if a 10-digit CLIA laboratory identification number is not present in item 23. This requirement applies to claims for services performed on or after January 1, 1998. RARC: MA120

Q. For investigational devices billed in an FDA-approved clinical trial if an Investigational Device Exemption (IDE) number is not present in item 23, for dates of service through March 31, 2008. RARC: MA50. With the use of new modifier Q0, effective for dates of service on and after April 1, 2008, contractors will no longer be able to distinguish an IDE claim from other investigational clinical services. Therefore this edit will no longer apply.

R. For physicians performing care plan oversight services if the 6-digit Medicare provider number of the home health agency (HHA) or hospice is not present in item 23.

S. For Competitive Acquisition Program drug and biological claims, in accordance with the instructions found in the Medicare Claims Processing Manual, chapter 17, section 100.2.1 – section 100.9.

T. For claims for artificial hearts covered by Medicare under an approved clinical trial, if procedure code 0051T is entered in Item 24D, and an 8-digit clinical trial number that matches an approved clinical trial listed at:

http://www.cms.hhs.gov/MedicareApprovedFacilitie/06_artificialhearts.asp#TopOfPage is not entered in Item 19; and the HCPCS modifier Q0 is not entered on the same line as the procedure code in Item 24D, and the diagnosis code V70.7 (if ICD-9-CM is applicable) or Z00.6 (if ICD-10-CM is applicable) is not entered in Item 21 and linked to the same procedure code.

For item T only: The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.

Group Code: CO
CARC: 4
RARC: N/A
MSN: N/A

U. For clinical trial claims processed **after September 28, 2009**, with dates of service on or after January 1, 2008, claims submitted with either the modifier QV or the modifier Q1, if the diagnosis code V70.7 (if ICD-9-CM is applicable) or Z00.6 (if ICD-10-CM is applicable) is not submitted with the claim.

V. For ambulance claims, claims submitted without the ZIP Code of the loaded ambulance trip's point-of-pickup in Item 23 of the CMS-1500 Form.

80.3.2.2 - Consistency Edits for Institutional Claims

(Rev. 12107; Issued:06-29-23; Effective: 04-01-23; Implementation: 01-02-24)

In order to be processed correctly and promptly, a bill must be completed accurately. Medicare contractors processing institutional claims edit all Medicare required fields as shown below. If a bill fails these edits, contractors return it to the provider for correction. If bill data is edited online, the edits are included in the software. Depending upon special services billed, contractors may require additional edits.

The following instructions follow the format of Form CMS-1450. For instructions about the location of these data elements on the ASC X12 837 institutional claim transaction format see the related implementation guide.

FL 4. Type of Bill

a. Must not be spaces.

b. Must be a valid code for billing. Valid codes are:

First Digit - Type of Facility:

1 - Hospital

NOTE: Hospital-based multi-unit complexes may also have use for the following first digits when billing non-hospital services:

2 - Skilled Nursing

3 - Home Health

4 - Religious Non-Medical (Hospital)

7 - Clinic or Renal Dialysis Facility (requires special information in second digit below)

8 - Special Facility or Hospital ASC Surgery (requires special information in second digit, see below)

Second Digit - Classification (if first digit is 1-5):

1 - Inpatient (Part A)

2 - Hospital-Based or Inpatient (Part B) (includes HHA visits under a Part B plan of treatment)

3 - Outpatient (includes HHA visits under a Part A plan of treatment and use of HHA DME under a Part A plan of treatment)

4 - Other (Part B) (includes HHA medical and other health services not under a plan of treatment, hospital and SNF for diagnostic clinical laboratory services for “nonpatients”)

8 - Swing bed (used to indicate billing for SNF level of care in a hospital with an approved swing bed agreement)

Second Digit - Classification (first digit is 7):

1 - Rural Health Clinic (RHC)

2 - Hospital-Based or Independent Renal Dialysis Facility

4 - Other Rehabilitation Facility (ORF)

5 - Comprehensive Outpatient Rehabilitation Facility (CORF)

6 - Community Mental Health Center (CMHC)

7 - Free-Standing Provider-Based Federally Qualified Health Center (FQHC)

Second Digit - Classification (first digit is 8):

1 - Hospice (Nonhospital-based)

2 - Hospice (Hospital-based)

5 - Critical Access Hospital (CAH)

Third Digit - Frequency:

A - Admission/Election Notice

B - Hospice/Medicare Coordinated Care Demonstration/Religious Non-Medical Health Care Institution-Termination/Revocation Notice

C - Hospice Change of Provider

D - Hospice/Medicare Coordinated Care Demonstration/Religious Non-Medical Health Care Institution-Void/Cancel

E - Hospice Change of Ownership

F - Beneficiary Initiated Adjustment Claim (For A/B MAC (A) use only)

G - CWF Initiated Adjustment Claim (For A/B MAC (A) use only)

H - CMS initiated Adjustment Claim (For A/B MAC (A) use only)

I - A/B MAC (A) Adjustment Claim (Other than QIO or Provider) (For A/B MAC (A) use only)

J - Initiated Adjustment Claim-Other (For A/B MAC (A) use only)

K - OIG Initiated Adjustment Claim (For A/B MAC (A) use only)

M - MSP Initiated Adjustment Claim (For A/B MAC (A) use only)

P - QIO Adjustment Claim (For A/B MAC (A) use only)

Q – Claim Submitted for Reconsideration Outside of Timely Limits (For A/B MAC (A) use only)

0 - Nonpayment/zero claims

1 - Admit Through Discharge Claim

2 - Interim - First Claim

3 - Interim – Continuing Claims (Not valid for PPS bills. Exception: SNF PPS bills)

4 - Interim – Last Claim (Not valid for PPS bills. Exception: SNF PPS bills)

5 - Late charge

7 - Correction

8 - Void/Cancel

9 - Final Claim for a Home Health PPS Episode

FL 6. Statement Covers Period (From - Through)

a. Cannot exceed eight positions in either “From” or “Through” portion allowing for separations (nonnumeric characters) in the third and sixth positions.

b. The “From” date must be a valid date that is not later than the “Through” date.

c. The “Through” date must be a valid date that is not later than the current date.

d. With the exception of Home Health PPS claims, the statement covers period may not span 2 accounting years.

FL 09. Patient’s Address

a. The address of the patient must include:

City
State (P.O. Code)
ZIP

b. Valid ZIP Code must be present if the type of bill is 11X, 13X, 18X, or 83X or 85X.

c. Cannot exceed 62 positions.

FL 10. Birthdate

a. Must be valid if present.

b. Cannot exceed 10 positions allowing for separations (nonnumeric characters) in the third and sixth positions.

FL 11. Sex

a. One alpha position.

b. Valid characters are “M” or “F.”

c. Must be present.

FL 12. Admission Date

a. Must be valid if present.

b. Cannot exceed eight positions allowing for separations (nonnumeric characters) in the third and sixth positions.

c. Present only if the type of bill is 11X, 12X, 18X, 21X, 22X, 32X, 33X, 41X, 81X or 82X.

FL 14. Priority (Type) of Admission or Visit

a. One numeric position.

b. Required only if the type of bill is 11X, 12X, 18X, 21X, 22X, or 41X.

FL 15. Point of Origin for Admission or Visit.

a. One numeric position

b. Must be present

FL 17. Patient Discharge Status.

a. Two numeric positions

b. Present on all Part A inpatient, SNF, hospice, home health agency, and outpatient hospital services. Types of bill: 11X, 12X, 13X, 14X, 18X, 21X, 22X, 23X, 32X, 33X, 34X, 41X, 71X, 73X, 74X, 75X, 76X, 81X, 82X, 83X, or 85X.

FL 03b. Medical/Health Record Number

a. If provided by the hospital, must be recorded by the A/B MAC (A) for the QIO.

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

FLs 18 thru 28. Condition Codes.

a. Each code is two numeric digits.

b. If code 07 is entered, type of bill must not be hospice 81X or 82X.

c. If codes 36, 37, 38, or 39 are entered, the type of bill must be 11X and the provider must be a non-PPS hospital or exempt unit.

d. If code 40 is entered, the "From" and "Through" dates in FL 6 must be equal, and there must be a "0" or "1" in FL 7 (Covered Days).

e. Only one code 70, 71, 72, 73, 74, 75, or 76 can be on an ESRD claim.

FLs 31, 32, 33, and 34. Occurrence Codes and Dates

a. All dates must be valid.

b. Each code must be accompanied by a date.

c. All codes are two alphanumeric positions.

d. If code 20 or 26 is entered, the type of bill must be 11X or 41X. If code 21 or 22 is entered, the type of bill must be 18X or 21X.

e. If code 27 is entered, the type of bill must be 81X or 82X.

f. If code 28 is entered, the first digit in FL 4 must be a "7" and the second digit a "5."

g. If code 42 is entered, the first digit in FL 4 must be "8" and the second digit "1" or "2" and the third digit "1 or 4."

h. If 01 - 04 is entered, Medicare cannot be the primary payer, i.e., Medicare-related entries cannot appear on the "A" lines of FLs 58-62.

i. If code 20 is entered:

- Must not be earlier than "Admission" date ~~(FL 17)~~ or later than "Through" date (FL 6).

- Must be less than 13 days after the admission date ~~(FL 17)~~ if "From" date is equal to admission date (less than 14 days if billing dates cover the period December 24 through January 2).

j. If code 21 is entered:

- Cannot be later than “Statement Covers Period” Through date; or
- Cannot be more than 3 days prior to the “Statement Covers Period” From date.

k. If code 22 is entered, the date must be within the billing period shown in FL 6.

l. If code 31 is entered, the type of bill must be 11X, 21X, or 41X.

m. If code 32 is entered, the type of bill must be 13X, 14X, 23X, 32X, 33X, 34X, 71X, 72X, 73X, 74X, 75X, 81X, or 82X.

FL 35 and 36. Occurrence Span Codes and Dates

a. Dates must be valid.

b. Code entry is two alphanumeric positions.

c. Code must be accompanied by dates.

d. If code 70 is entered, the type of bill must be 11X, 18X, 21X, or 41X.

e. If code 71 is entered, the first digit of FL 4 must be “1,” “2,” or “4” and the second digit must be “1.”

f. If code 72 is entered, the type of bill must be 11X, 12X, 13X, 14X, 18X, 21X, 22X, 23X, 32X, 34X, 71X, 72X, 73X, 74X, 75X, 76X, 77X, 81X, 82X, or 85X.

g. If code 74 is entered, the type of bill must be 11X, 13X, 14X, 18X, 21X, 34X, 41X, 71X, 72X, 74X, 75X, 81X, or 82X.

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

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

j. If code 76 is entered, occurrence code 32 must be present (outpatient only).

k. If code 76, 77, or M1 is present, the bill type must be 11X, 13X, 14X, 18X, 21X, 34X, 41X, 71X, 72X, 73X, 74X, 75X, 81X, 82X, or 85X.

l. Neither the “From” nor the “Through” portion can exceed eight positions allowing for separations (nonnumeric characters) in the third and sixth positions of each field.

m. If code M2 is present, the bill type must be 81X or 82X.

n. Code 79 is for payer use only. Providers do not report this code.

FLs 39, 40, and 41. Value Codes and Amounts.

a. Each code must be accompanied by an amount.

b. All codes are two alphanumeric digits.

c. Amounts may be up to ten numeric positions. (00000000.00)

d. If code 06 is entered, there must be an entry for code 37.

e. If codes 08 and/or 10 are entered, there must be an entry in FL 10.

f. If codes 09 and/or 11 are entered, there must be an entry in FL 9.

g. If codes 12, 13, 14, 15, 41, 43, or 47 are entered as zeros, occurrence codes 01, 02, 03, 04, or 24 must be present.

h. Entries for codes 37, 38, and 39 cannot exceed three numeric positions.

i. If the blood usage data is present, code 37 must be numeric and greater than zero.

FL 42. Revenue Codes.

a. Four numeric positions.

b. Must be listed in ascending numeric sequence except for the final entry, which must be “0001” for hardcopy claims only.

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

d. For bill types 32X and 33X the following revenue codes require a 5-position HCPCS code:

0274, 029X, 042X, 043X, 044X, 055X, 056X, 057X, 0601, 0602, 0603, and 0604.

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

0271-0274, 42X, 43X, 44X, and 0601-0604.

f. For bill type 21X, 32X, 33X, or 11X (IRF facilities) the following revenue codes require a 5-position HIPPS code:

0022 (SNF only), 0023 (HH only), 0024 (IRFs only).

FL 45. Service Date

a. Six numeric positions, MMDDYY.

b. A single line item date of service (LIDOS) is required on every revenue code present on types of bill 12X, 13X, 14X, 22X, 23X, 24X, 32X, 33X, 34X, 71X, 73X, 74X, 75X, 76X, 81X, 82X, and 83X.

Exception: LIDOS are not required for CAHs, Indian Health Service hospitals, and hospitals located in American Samoa, Guam, and Saipan.

c. When a particular service is rendered more than once during the billing period, the revenue code and HCPCS code must be entered separately for each service date.

FL 46. Units of Service

a. Up to seven numeric positions.

b. Must be present for all services with the exception of the HIPPS line item service. (Exception: Units are required on the HIPPS line for SNF claims)

c. Accommodation units must equal covered days with the exception of the R No-Pay.

FL 47. Total Charges

a. Up to 10 numeric positions (00000000.00).

b. There must be an entry adjacent to each entry in FL 42.

c. The “0001” amount must be the sum of all the entries for hardcopy only.

FLs 50A, B, and C. Payer Identification

a. "Medicare” must be entered on one of these lines depending upon whether it is the primary, secondary or tertiary payer.

b. If value codes 12, 13, 14, 15, 16, 41, 42, 43, or 47 are present, data pertaining to Medicare cannot be entered in Line A of FLs 50-62.

FL 56. National Provider Identifier – Billing Provider

a. Effective May 23, 2007, providers are required to submit their NPI.

b. Left justified.

FLs 58A, B, and C. Insured's Name

a. Must be present. Cannot be all spaces.

FLs 60A, B, and C. Certificate/Social Security Number/HI Claim/Identification Number

a. Must be present.

b. Must contain nine numeric characters and at least one alpha character as a suffix. The first alpha suffix is entered in position 10, the second in position 11, etc. The first three numbers must fall within the range of 001 through 680 or 700 through 728.

c. The alpha suffix must be A through F, H, J, K, M, T, or W. Alpha suffixes A and T must not have a numeric subscript. Alpha suffixes B, C, D, E, F, M, and W may or may not have a numeric subscript.

d. If the alpha suffix is H, it must be followed by A, B or C in position eleven. The numeric subscript (position twelve) must conform with the above for the A, B, or C suffix to be used.

e. RRB claim numbers must contain either six or nine numeric characters, and must have one, two, or three-character alpha prefix.

f. For prefixes H, MH, WH, WCH, PH and JA only a 6-digit numeric field is permissible. For all other prefixes, a six or nine numeric field is permissible.

g. Nine numeric character claim numbers must have the same ranges as the SSA 9-position claim numbers.

FL 67. Principal Diagnosis Code and Present on Admission Indicator.

a. If ICD-9-CM, must be four or five positions left justified, with no decimal points. If ICD-10-CM, must be three to seven positions, left justified, with no decimal points.

b. Must be valid ICD diagnosis code for date of service.

c. POA is a one position field.

FLs 67 A - Q. Other Diagnosis Codes and Present on Admission Indicator.

a. If present, for ICD-9-CM must be four or five positions, left justified, with no decimal points. For ICD-10-CM must be three to seven positions, left justified, with no decimal points.

b. POA is a one position field.

FL 74. Principal Procedure Code and Date

a. If present, must be valid procedure code for service date. For ICD-9-CM must be 3 - 5 characters; first character may be numeric or alpha, characters 2 -5 must be numeric. For ICD-10-PCS must be 3 - 7 characters; first character must be alpha, second character must be numeric, characters 3 – 7 may be alpha or numeric.

b. If code is present, date must be present and valid.

c. Date must fall before the "Through" date in FL 6. (In some cases it may be before the admission date, i.e., where complications and admission ensue from outpatient surgery.)

FL 74 a-e. Other Procedure Codes and Dates.

a. If present, apply edits for FL 74

FL 76. Attending Provider Name and Identifiers.

a. The UPIN must be present on inpatient Part A bills with a "Through" date of January 1, 1992, or later. For outpatient and other Part B services, the UPIN must be present if the "From" date is January 1, 1992, or later. This requirement applies to all provider types and all Part B bill types. Effective May 23, 2007, providers are required to submit NPI.

b. An institutional provider may not submit their own NPI, except for Institutional billing of COVID-19, influenza, and pneumococcal vaccinations and their administration as the only billed service on a claim, roster billing of COVID-19, influenza, and pneumococcal vaccinations and their administrations, self-referred screening mammography as the only billed service on a claim, HCPCS K1034 as the only billed service on a claim, or where the provider only has a type-1 NPI as a physician/practitioner owned sole-proprietor (i.e., RHC).

c. An institutional provider may not submit an organizational type-2 NPI in the attending NPI field except as noted above in "b".

FL 77. Operating Physician Name and Identifiers

a. Effective May 23, 2007, providers are required to submit NPI. NPI must be present if:

- Bill type is 11X and a procedure code is shown in FL 74;
- Bill type is 83X or 13X and a HCPCS code is reported that is subject to the ASC payment limitation or is on the list of codes the QIO furnishes that require approval; or
- Bill type is 85X and HCPCS code is in the range of 10000 through 69979.

b. If required:

- NPI, last name and first initial must be present; and
- Left justified.

80.3.3 - Timeliness Standards for Processing Other-Than-Clean Claims

(Rev. 4201, Issued: 01-18-19, Effective: 02-19-19, Implementation: 02-19-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

The Social Security Act, at §1869(a)(2), mandates that Medicare process all "other-than-clean" claims and notify the individual filing such claims of the determination within 45 days of receiving such claims.

Claims that do not meet the definition of "clean" claims are "other-than-clean" claims. "Other-than-clean" claims require investigation or development external to the contractor's Medicare operation on a prepayment basis.

The contractor shall process all "other-than-clean" claims and notify the provider and provider of the determination within 45 calendar days of receipt. (See Pub100-4, Chapter 1, §80.2.1 for the definition of "receipt date" and for timeliness standards for clean claims.) However, when the contractor develops to the provider/supplier or beneficiary for additional information, the contractor shall cease counting the 45 calendar days on the day that the contractor sends the development letter. Upon receiving the materials

requested in the development letter from the provider/supplier and/or beneficiary, the contractor shall resume counting the 45 calendar days.

EXAMPLE:

The contractor receives a claim on June 1st, but does not send a development letter to the provider/supplier/ and/or beneficiary until June 5th. In this situation, 5 of the 45 allotted calendar days will have already passed before the contractor requested the additional information. Upon receiving the information back from the provider/supplier and/or beneficiary, the contractor has 40 calendar days left to process the claim and notify the individual that filed the claim of the payment determination for that claim.

Contractors shall follow existing procedures relative to both the length of time the provider/supplier and/or beneficiary is afforded to return information requested in the development letters and situations where the provider/supplier and or beneficiary does not respond.

Contractors shall report the number of other-than-clean claims processed in 45 days or less on Form Y of the Contractor Reporting of Operational and Workload Data (CROWD) report. Use identifier code "0005" in column 1 to report this information. Report the number of other-than-clean claims processed in 46 days or longer on Form Y of the CROWD system, under column 1 on a line using code "0006" as the identifier.

The following types of claims do not apply to this instruction:

- Claims where the Social Security Administration blocks a beneficiary's Medicare beneficiary identifier,
- Claims the contractors are required to hold due to CMS instructions,
- Translator rejects,
- Claims where CWF is unable to process due to technical issues with the CWF beneficiary record or beneficiary identification issues,
- Claims submitted by a hospice, and
- Claims in development due to processing requirements (e.g. medical review), in Publication 100-8, the Medicare Program Integrity Manual.

80.4 - Enforcement of Provider Billing Timelines and Accuracy Standard to Continue PIP (Periodic Interim Payment)

(Rev. 4201, Issued: 01-18-19, Effective: 02-19-19, Implementation: 02-19-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare

beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

A. General

To remain on PIP, providers, (with the exception of HHAs that do not receive PIP with the advent of PPS mandated by law on October 1, 2000), must submit 85 percent of their bills timely and accurately. Timely and accurately means that 85 percent of its bills (excluding those listed below) are submitted within 30 days of discharge and pass front-end edits for consistency and completeness. A bill is not considered received unless it can pass FI edits. FIs must accumulate statistics on inpatient and SNF billing performance for each PIP provider to monitor whether it meets this requirement. These instructions do not effect bi-weekly payments for pass-throughs (Medicare Provider Reimbursement Manual, (PRM) §2405.2) and for adjustments to indirect cost for medical education (PRM §2405.3).

The evaluation for timeliness of billing should be consistent with the frequency for monitoring the payment amounts under the PIP program. Thus, for non-PPS hospitals and SNFs the evaluation process is scheduled at 3-month intervals and PPS providers are evaluated every 4 months. The evaluation includes data from the entire 3- or 4-month period. In determining whether a provider submitted its bills within 30 days of discharge or through date on interim bills, count the date from Form CMS-1450 FL6 (through date) to the date received by the FI. If the provider does not meet the criteria, discontinue PIP immediately. The periodic performance report that is provided in accordance with subsection B will constitute advance notice before discontinuing PIP.

Exclude the following:

- MSP cases (value codes 12-16);
- Any special situation identified by the provider or FI that is documented as beyond provider control. Exclusions must be approved by the RO; and
- Bills that have not passed FI front-end edits for acceptance. (Such bills are counted only when acceptable to the shared system edit processes.)

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

B. Procedure for Measuring and Reporting to Hospitals and SNFs

The FIs accumulate a record for each bill that passes front-end edits. Bills must be counted in the month received regardless of the discharge month. No later than 10 work-days after the end of the month, FIs furnish a report to each hospital/SNF. For the month indicating the following:

- The total number of bills received;
- The number not excluded as described in section A;
- The number not excluded received in 30 days or less;
- The percentage not excluded received in 30 days or less.

Also, for providers that fail to meet the standard, furnish individual case identification of claims that were not billed within 30 days of discharge. List only claims that are not excluded and are identified in subsection A. The report must be furnished in electronic media, unless the FI determines a paper listing would be cheaper to process. If electronic media is used, use the following record format. Determine the physical characteristics of the file.

Fld	Description	Psn.	Picture	Just	From	Thru
1	Provider Number	6	X(6)	L	001	006
2	Blank	3	X(3)		007	009
3	Blank	1	X		010	
4	Medicare beneficiary identifier	12	X(12)	L	011	022
5	Blank	1	X		023	
6	Beneficiary Surname	6	X(6)	L	024	029
7	Blank	1	X		030	
8	Patient Control Number	17	X(17)	L	031	047
9	Blank	1	X		048	
10	From Date	6	9(6)		049	054
11	Blank	1	X		055	
12	Discharge or Thru Date	6	9(6)		056	061
13	Blank	1	X		062	
14	Date Bill Received	6	9(6)		063	068
15	Blank	1	X		069	
16	Days Elapsed	4	9(4)	R	070	073

If sub-provider identification is used, positions 7, 8, and 9 may be utilized.

C. Reinstatement of PIP

Do not reinstate PIP for a provider until it meets all criteria in PRM §§2405.1.B and 2407 and has met the requirements in subsection A for timeliness and accuracy for six consecutive months.

D. New Request for PIP

Evaluate new requests for PIP as in subsections A and B. At least three months experience is required for new requests, (except for new providers with less experience).

E. Hospitals on 100 Percent PRO Prepayment Review

The 30-day requirements for submitting bills to FIs are not applicable. The RO makes determinations of timely and accurate bill submission by hospitals for which the PRO reviews 100 percent of the discharges before payment. However, other standards remain applicable for retaining PIP in such cases. See PRM §§2405.1.B and 2407 for the requirements.

80.5 - Do Not Forward Initiative (DNF)

(Rev. 1, 10-01-03)

80.5.1 - Carrier DNF Requirements

(Rev. 1, 10-01-03)

B3-4021, B-02-023

This initiative entails the use of "Return Service Requested" envelopes to preclude the forwarding of Medicare checks to locations other than those recorded on the Medicare provider files. The use of these envelopes permit the U.S. Postal Service to return Medicare checks to local carriers and durable medical equipment regional carriers (DMERCs) free of charge, as the postal service has done for the DMERCs since February 1997.

A. Returned Check Process for Carriers and DMERCs

The CMS requires carriers and DMERCs to use "Return Service Requested" envelopes for all checks they mail to providers and suppliers. In addition, carriers and DMERCs must use "return service requested" envelopes for hardcopy remittance advices, with respect to providers that have elected to receive hardcopy remittance advices. They do not use "return service requested" envelopes for beneficiary correspondence, such as Explanations of Benefits (EOB) or Medicare Summary Notices (MSNs), or for overpayment demand letters.

Carriers and DMERCs must be in compliance with postal regulations when developing their DNF envelopes. Carriers and DMERCs must sort outgoing mail to identify provider or supplier checks, and must only place these checks in "Return Service Requested" envelopes. The postal service will forward remittance advice without checks and checks to beneficiaries.

When the check is returned, if applicable, the postal service will provide the carrier or DMERC with a new address or reason for nondelivery. If the postal service supplies a carrier or DMERC with a new address for the provider or supplier with the returned check or remittance, do not automatically change the address of the provider or supplier or re-mail the check/remittance. (See the change of address process described below.)

Once the post office returns an envelope, record the check number and any correspondence in the envelope, using normal procedures for incoming mail. For example, microfiche, and photocopy the mail. Contractors must also log and account for the checks, noting pertinent information, such as the provider or supplier's name and number, date of the check, the check number, the amount of the check, and the date the check was returned.

The carrier's or DMERC's financial staff must either reissue the check based upon receipt of an updated, verified address, or systematically cancel the returned check and notify the provider enrollment staff that a provider must be flagged DNF. The provider enrollment staff must annotate the provider or supplier's file with a DNF flag, pending receipt of a verified address. Carriers and DMERCs must process any subsequent claims a flagged provider or supplier submits through the Common Working File (CWF) to completion, but must not generate any additional check or checks for that provider or supplier until an authorized address correction is received and the flag removed.

In addition, provider enrollment staff must alert the benefit integrity staff in the event that any investigations are currently taking place, which are affiliated with flagged providers or suppliers. DMERCs must notify the National Supplier Clearing House (NSC). All carriers must implement a standardized reporting format for this process.

NOTE: Because some providers get paid through electronic funds transfer (EFT), there may be cases where a provider does not have a correct address on file, but the contractor continues to pay the provider through EFT. This instruction applies to providers receiving paper.

B. Change of Address Process for Local Carriers and DMERCs

When a flagged provider or supplier notifies you that they have not received their checks, direct them to your provider enrollment staff. The provider or supplier must complete a change of address Form CMS-855C, or other written notification. The form or written notification must bear an original signature from an authorized representative of the entity that completed the original registration form. No copies, faxes, or stamps are acceptable. For purposes of this process, the most important address is the "Pay To" address. If the provider or supplier did not furnish the "Pay To" address on Form CMS-855C, or other written notification, return it to the provider or supplier. The provider or supplier must furnish the "Pay To" address. Addresses may not be changed based on telephone calls.

Although the Pay to Address is the most critical, CMS requires corrections to all addresses before the contractor can remove the DNF flag and begin paying the provider or supplier again. Therefore, carriers may not release any payments to DNF providers until the provider enrollment area or the NSC has verified and updated all addresses for that provider's location

When a provider enrollment staff member verifies an address, the provider must update the address for the provider or supplier and remove the DNF flag.

Provider enrollment staff must send a daily report to financial staff, advising which providers and suppliers are no longer flagged DNF. Financial staff must generate all payment that is due the provider or supplier for claims that were adjudicated for the time period the provider or supplier was flagged.

C. Educational Requirements

1. Contractors must publish the requirement that providers must notify the Part B carrier or NSC of any changes of address, both on their Web sites and in their next regularly scheduled bulletins.
2. Contractors must continue to remind suppliers and providers of this requirement in their bulletins at least yearly thereafter.

80.5.1.1 - Reporting Requirements - Carriers

(Rev. 2228, Issued: 05-20-11, Effective:06-06-11, Implementation:06-06-11)

A. Field Definitions for DNF Spreadsheet

To be certain that all parties understand what information CMS needs to get from these reports, the following definitions have been created for each field. No rolling or annual totals should be included.

Suppliers/Providers Flagged/Corrected Counts Field #	Definition
1	New Flags: the number of all suppliers or providers the contractor flagged for DNF during the reporting quarter (regardless of whether or not they still have a flag, and regardless of whether the contractor flagged them due to a returned check or

	returned remittance advice), that were not flagged at the end of the previous reporting quarter.
2	Removed Flags: the number of all suppliers or providers who supplied a verified, correct address, causing the contractor to remove the DNF flag, during the reporting quarter.
3	Total Flags: the total number of all suppliers or providers who still have a DNF flag on the last day of the reporting quarter, regardless of whether the contractor flagged them due to a returned check or returned remittance advice), including those the contractor flagged in a previous quarter who did not supply a verified, corrected address.

Check Counts Field #	**Definition**
4	Returned Checks: the total number of checks the post office returned to the contractor due to an incorrect address during the reporting quarter, regardless of whether or not the supplier provided a corrected address and may have been reissued the check during the quarter.
5	Held Checks: the total number of all checks that contractors did not issue due to DNF flags in the system during the reporting quarter, regardless of whether or not the supplier provided a corrected address and was later paid.
6	Reissued and Released Checks: the total number of all checks (both those the post office returned, and those the contractor had been holding due to a DNF flag in the system) the contractors reissued or released during the reporting quarter, to suppliers or providers who submitted a verified, correct address.

Dollar Counts Field #	**Definition**
7	Amount Returned: the total dollar amount of all checks the post office returned due to an incorrect address during the

	reporting quarter, that you are still holding at the end of the reporting quarter.
8	Amount Held: the total dollar amount of all checks the contractors did not issue due to DNF flags in the system during the reporting quarter, that you are still holding at the end of the reporting quarter.
9	Amount Reissued/Released: the total dollar amount of all payments (both those the post office returned, and those the contractor had been holding due to a DNF flag in the system) the contractors reissued during the reporting quarter, to suppliers or providers who submitted a verified, correct address.
10	Net Amount: the value in field 7 plus the value in field 8, minus the value in field 9 - it is possible that this number will be a negative figure.

NOTE A

If a contractor flags a provider or supplier for DNF more than one time within a quarter, only count that supplier or provider once for fields 1, 2, and 3.

NOTE B

Multi-Carrier Systems contractors may use a claim count for items 4-6, 8, and 9, rather than a check count.

B. Systems Requirements

Carriers and DMERCs generate reports out of the shared systems and must be able to generate figures for each field in accordance with the above descriptions.

Furthermore, shared systems must be certain that when the system calculates the totals, it includes the first returned check that prompted the DNF flag. The shared systems should program the reports so that the contractors may request monthly detail reports to verify the quarterly totals. However, carriers only send the quarterly reports to CMS central office (CO) and regional office (RO), not the monthly reports.

C. Quarterly Reporting Requirements

All contractors must submit their DNF reports by the fifteenth day of each month that follows the end of a quarter (i.e., January 15, April 15, July 15, and October 15). The instructions for the current process are defined in Section F, Deliverable Schedule, of

each individual contract. Contractors (A/B MACs and DME MACs) must submit their DNF reports to CMS Automated Reporting Tracking System (CMS ARTs). Legacy Contractors (Carriers) must submit their DNF reports to their appropriate CMS Central Office contact.

D. Other Requirements

Contractors must continue to follow all other aspects of the DNF reporting initiative (e.g., use of "Return Service Requested" envelopes, assignment of a DNF flag to appropriate providers/suppliers) as instructed in the §80.5.

E. Examples - Blank Report

DO NOT FORWARD PROJECT			
Activity for the _____ Quarter of FY _____	**$$**	**Region**	**Medicare Contractor**
Suppliers/Providers Flagged/Correct Counts			
1. # new supplier/providers flagged during the reporting quarter			
2. # suppliers/providers whose flags were removed, end of the reporting quarter			
3. # suppliers/providers flagged, end of the reporting quarter			
Check Counts			
4. # new checks returned during the reporting quarter			
5. # of checks held during the reporting quarter			
6. # checks reissued during the reporting quarter			
Dollar Counts			
7. **$** amount of new checks returned during the reporting quarter			
8. **$** amount of checks held during the reporting quarter			
9. **$** amount reissued during the reporting quarter			
10. **$** amount returned to trust fund during the reporting quarter			
Report By:_____			
Report Date:_____			

Sample Completed Report

SAMPLE - DO NOT FORWARD PROJECT			
Activity for the 3RD Quarter of FY 2003	**$$**	**Region**	**Medicare Contractor**
		Q	**XYZ Contractor**
Suppliers/Providers Flagged/Correct Counts			
1. # new supplier/providers flagged during the reporting quarter	125		
2. # suppliers/providers whose flags were removed, end of the reporting quarter	30		
3. # suppliers/providers flagged, end of the reporting quarter	117		
Check Counts			
4. # new checks returned during the reporting quarter	40		
5. # of checks held during the reporting quarter	100		
6. # checks reissued during the reporting quarter	60		
Dollar Counts			
7. **$** amount of new checks returned during the reporting quarter	100,000		
8. **$** amount of checks held during the reporting quarter	600,000		
9. **$** amount reissued during the reporting quarter	500,000		
10. **$** amount returned to trust fund during the reporting quarter	200,000		
Report By: Jane Doe			
Report Date: April 02, 2003			

80.6 – Processing All Diagnosis Codes Reported on Claims Submitted to Carriers

(Rev.735, Issued: 10-31-05, Effective: 04-01-06, Implementation: 04-03-06)

Carrier standard systems shall capture and process all diagnosis codes reported on a claim (both paper and electronic) up to the maximum permitted under the format. The CWF shall process and maintain all diagnosis codes reported to CWF on a carrier processed claim.

90 - Patient Is a Member of a Medicare Advantage (MA) Organization for Only a Portion of the Billing Period

(Rev. 11731, Issued: 12-09-22, Effective: 01-11-23, Implementation: 01-11-23)

Where a patient either enrolls or disenrolls in an MA organization (See Pub. 100-01, the General Information, Eligibility, and Entitlement Manual, Chapter 5, §80 for definition) during a period of services, two factors determine whether the MA organization is liable for the payment.

- Whether the provider is included in inpatient hospital or home health PPS, and
- The date of enrollment.

Hospital Services

If the provider is an inpatient acute care hospital, inpatient rehabilitation facility or a long term care hospital, and the patient changes MA status during an inpatient stay for an inpatient institution, the patient's status at admission or start of care determines liability. If the hospital inpatient was not an MA enrollee upon admission but enrolls before discharge, the MA organization is not responsible for payment.

For hospitals exempt from PPS (children's hospitals, cancer hospitals, CAHs and Maryland waiver hospitals), if the MA organization has processing jurisdiction for the MA involved portion of the bill, it will direct the provider to split the bill and send the appropriate portions to the appropriate FI or MA organization. When forwarding a bill to an MA organization, the provider must also submit the necessary supporting documents. If the provider is not a PPS provider, the MA organization is responsible for payment for services on and after the day of enrollment up through the day that disenrollment is effective.

Home Health

If the patient was enrolled in the MA organization before start of care, the MA organization is liable until disenrollment. Upon disenrollment, an episode must be opened under home heath PPS for billing to the FI.

If the beneficiary was not an MA enrollee upon admission but enrolls before discharge, the home health PPS episode will end as of the day before the MA enrollment. The episode will be proportionately paid according to its shortened length (i.e., paid a partial episode payment [PEP] adjustment). The MA organization is responsible for payment as of the MA enrollment date.

91 - Moral and Religious Fee for Service Claims for Medicare Beneficiaries Enrolled in Certain Medicare Advantage (MA) Plans

100 - Medicare as a Secondary Payer

(Rev. 1, 10-01-03)

HO-301, HO-469, CFR 411.32

The provider is required to determine whether Medicare is a primary or secondary payer for each inpatient admission of a Medicare beneficiary and outpatient encounter with a Medicare beneficiary. Refer to the Medicare Secondary Payer Manual for specific MSP rules and for special admission and claims processing procedures for providers, suppliers, FIs, and carriers.

Medicare benefits are secondary to benefits payable by a third party payer, even if State law or the third party payer states that its benefits are secondary to Medicare benefits or otherwise limits its payments to Medicare beneficiaries. Medicare will make secondary payments except when the provider or supplier is either obligated to accept, or voluntarily accepts, as full payment, a third party payment that is less than its charges. When a provider or supplier, or a beneficiary who is not physically or mentally incapacitated, receives a reduced third party payment because of failure to file a proper claim, the Medicare secondary payment may not exceed the amount that would have been payable if the third party payer had paid on the basis of a proper claim.

The law mandates that Medicare is secondary payer for:

- Claims involving Medicare beneficiaries age 65 or older who have GHP coverage based upon their own current employment status with an employer that has 20 or more employees, or that of their spouse of any age, or based upon coverage by a multiple employer, or multi-employer group health plan by virtue of their own, or a spouse's, current employment status and the GHP covers at least one employer with 20 or more employees. An individual has current employment status if the individual is actively working as an employee, is the employer (including a self-employed person), or is associated with the employer in a business relationship; or is not actively working, but meets all of the following conditions:
    - o Retains employment rights in the industry;
    - o Has not had employment terminated by the employer,
    - o Is not receiving disability payments from an employer for more than six months;
    - o Is not receiving social security disability benefits; and
    - o Has group health plan (GHP) coverage based on employment that is not COBRA continuation coverage.

Examples of individuals who fall in the second group are teachers, employees who are on furlough or sick leave, and active union members between jobs.

- Claims involving beneficiaries eligible for or entitled to Medicare on the basis of end stage renal disease (ESRD) during a period of 30 months) except where an aged or disabled beneficiary had GHP or LGHP coverage which was secondary to Medicare at the time ESRD occurred;

NOTE: The Balanced Budget Act of 1997 extended the ESRD coordination period to 30 months from 18 months for any individual whose coordination period began on or after March 1, 1996. Individuals whose period began before that date have an 18-month coordination period. This issue may need to be clarified with ESRD beneficiaries upon admission.

- Claims involving automobile or non-automobile liability or no-fault insurance;
- Claims involving government programs, e.g., Worker's Compensation (WC), services authorized and paid for by the Department of Veterans Affairs (DVA), or Black Lung (BL) benefits; and
- Claims involving Medicare beneficiaries under age 65 who are entitled to Medicare on the basis of disability and are covered by an LGHP (plans or employers, or employee organizations, with at least one participating employer that employs 100 or more employees) based upon the beneficiary's own current employment status or the current employment status of a family member.

110 - Provider Retention of Health Insurance Records

(Rev. 1, 10-01-03)

HO-413, HH-480, SNF-545

The provider must maintain health insurance materials related to services rendered under title XVIII for the retention periods outlined below unless State law stipulates a longer period. It must keep them available for reference by CMS, carrier, or FI, DHHS audit, or specially designated components for bill review, audit, and other references.

110.1 - Categories of Health Insurance Records to Be Retained

(Rev. 1, 10-01-03)

HO-413, HH-480, SNF-545.1

Providers retain records in all categories as applicable:

A. Billing Material

Provider copies of Form CMS-1450 and any other supporting documents, e.g., charge slips, daily patient census records, and other business and accounting records referring to specific claims.

B. Cost Report Material

All data necessary to support the accuracy of the entries on the annual cost reports, including original invoices, cancelled checks, and provider copies of material used in preparing them. Also include other similar cost reports, schedules, and related worksheets and contracts or records of dealings with outside sources of medical supplies and services or with related organizations.

C. Medical Record Material

For hospitals, utilization review committee reports and discharge summaries. For hospitals and home health agencies, physicians' certifications, and recertifications, and clinical and other medical records relating to health insurance claims.

D. Provider Physician Materials

Provider physician agreements upon which Part A and Part B allocations are based. After payment of the bill, the provider should not retain administrative and billing work records if the material does not represent critical detail in support of summaries related to these records. These include punch cards, adding machine tapes, or other similar material not required for record retention.

110.2 - Microfilming Records

(Rev. 1, 10-01-03)

SNF-545.3, HO-413, HH-480

The provider may microfilm all health insurance records.

Billing material and related attachments that the provider furnished to the carrier or FI may be microfilmed providing the microfilm accurately reproduces all original documents.

The provider must retain copies of all other categories of health insurance records in their original form. If it microfilms them, it should store them in a low cost facility for the retention period described in §110.3.

110.3 - Retention Period

(Rev. 1, 10-01-03)

The hospital must maintain a medical record for each inpatient and outpatient. Medical records must be accurately written, promptly completed, properly filed and retained, and accessible. The provider must use a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries.

The provider (hospital, skilled nursing facility, and home health agency) must retain medical records in their original or legally reproduced form for a period of at least five years after it files with its FI the cost report to which the records apply, unless State law stipulates a longer period of time.

After payment of the bill, the provider need not retain administrative and billing work records provided that, and only to the extent that, such material does not represent critical detail in support of summaries related to the records outlined in §110.2. These records include punch cards, adding machine tapes, internal controls, or other similar material not required for record retention.

Providers must retain clinical records as follows:

- The period of time required by State law;
- Five years from the date of discharge when there is no requirement in State law; or
- For a minor, three years after a resident reaches legal age under State law.

110.4 - Destruction of Records

(Rev. 1, 10-01-03)

HO-413.1, HH-480.1, SNF-545.4

The provider may destroy material that no longer needs to be retained for title XVIII purposes, unless State law stipulates a longer period of retention.

To insure the confidentiality of the records, they must be destroyed by shredding, mutilation or other protective measures. The method of final disposition of the records may provide for their sale as salvage. The provider must report monies received as an adjustment to expense in the cost report for the year sold.

120 - Detection of Duplicate Claims

(Rev. 2678, Issued: 03-29-13, Effective: 04-29-13, Implementation: 04-29-13)

120.1 - Overview
(Rev. 2678, Issued: 03-29-13, Effective: 04-29-13, Implementation: 04-29-13)

The claims processing systems contain edits which identify exact duplicate claims and suspect duplicate claims. All exact duplicate claims or claim lines are auto-denied or rejected (absent appropriate modifiers). Suspect duplicate claims and claim lines are suspended and reviewed by the claims administration contractors to make a determination to pay or deny the claim or claim line.

Some claims that appear to be duplicates are actually claims or claim lines that contain an item or service, or multiple instances of an item or service, for which Medicare payment may be made. Correct coding rules applicable to all billers of health care claims encourage the appropriate use of condition codes or modifiers to identify claims that may appear to be duplicates, but, in fact, are not.

For example, there are some HCPCS modifiers that are appropriate to be appended to some services and can indicate that a claim line is not a duplicate of a previous line on the claim. Level I modifiers would typically be used by a biller to indicate that a potential duplicate claim or claim line is not, in fact, a duplicate. Level II modifiers may also be used. The Level II modifiers "RT" and "LT", for example, indicate that a service was performed on the right and left side of the body, respectively.

However, not every HCPCS code has an associated modifier to indicate that a claim line is not a duplicate. In that case, the claims and claim lines are reviewed by Medicare contactors' local software modules for a determination or they suspend for contractor review.

120.2 - Exact Duplicates
(Rev. 4201, Issued: 01-18-19, Effective: 02-19-19, Implementation: 02-19-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

Exact duplicates are controlled by the claims processing system through "hard coded" edits, and may not be user-controlled. In addition, Medicare contractors cannot override or bypass exact duplicate edits.

A. Submission of Institutional Claims

Claims or claim lines that have been determined to be an exact duplicate are rejected and do not have appeal rights. An exact duplicate for institutional claims is a claim or claim

line that exactly matches another claim or claim line with respect to the following elements:

- Medicare beneficiary identifier;
- Type of Bill;
- Provider Identification Number;
- From Date of Service;
- Through Date of Service;
- Total Charges (on the line or on the bill); and
- HCPCS, CPT-4, or Procedure Code modifiers.

Additional Instructions for Institutional Claims:

Whenever any of the following claim situations occur, the MAC develops procedures to prevent duplicate payment of claims. This includes, but is not limited to:

- Outpatient payment is claimed where the date of service is totally within inpatient dates of service at the same or another provider. Do not consider outpatient services provided on the day of discharge within the inpatient dates of service.

- Outpatient bill is submitted for services on the day of an inpatient admission or the day before the day of admission to the same hospital.

- Outpatient bill overlaps an inpatient admission period.

- Outpatient bill for services matches another outpatient bill with a service date for the same revenue code at the same provider or under a different provider number.

1. History File - Paid Claims

The MACs and legacy claims administration contractors must maintain a history file containing information about each claim processed. The file may consist of the claim or information from it. It must contain the following minimum information:

  - Medicare beneficiary identifier;
  - Beneficiary name information;
  - Provider identification (name or number); and
  - Billing period from the claim.

Claims or claims information in the history file may be transferred to inactive files. However, the MAC must have the facility to recall such claims or information if a claim for the beneficiary involving the same time period is received.

2. History File - Pending Claims

Contractors must have controls to prevent a duplicate claim from being paid while two claims are in the process within the system at the same time. This may be accomplished through a special check of in-process claims or in the history file for paid claims. The file should contain the same minimum information indicated in the subsections below. The check should be performed prior to sending the claim to CWF.

3. Analysis of Patterns of Duplicate Claims

The contractors shall establish a system for continuing analysis of duplicate claims. This includes the systematic evaluation of returned "Medicare Summary Notices" from beneficiaries and communications from providers indicating a duplicate payment has been made, as well as returned checks from any payee.

The contractor's system should provide for analyzing duplicate claim receipts to determine whether certain providers are responsible for duplicates and, if so, identify those providers. The contractor should educate such providers to reduce the number of duplicates they submit. Should those providers continue to submit duplicate claims, the MAC should initiate program integrity action.

B. Claims Submitted by Physicians, Practitioners, and other Suppliers (except DMEPOS Suppliers)

Claims or claim lines that have been determined to be exact duplicates of another claim or claim line are denied. However, such denials may be appealed. An exact duplicate for physician and other supplier claims submitted to a MAC or carrier is a claim or claim line that exactly matches another claim or claim line with respect to the following elements:

- Medicare beneficiary identifier;
- Provider Number;
- From Date of Service;
- Through Date of Service;
- Type of Service;
- Procedure Code;
- Place of Service; and
- Billed Amount.

C. Claims Submitted by DMEPOS Suppliers

Claims or claim lines that have been determined to be exact duplicates of another claim or claim line are denied. Such denials may not be appealed. An exact duplicate for DMEPOS supplier claims submitted to a DME MAC is a claim or claim line that exactly matches another claim or claim line with respect to the following elements:

- Medicare beneficiary identifier;
- From Date of Service;
- Through Date of Service;

- Place of service;
- HCPCS code;
- Type of Service;
- Billed Amount;
- Supplier

D. Claims Submitted by Multiple DMEPOS Suppliers

When a second DMEPOS supplier or multiple DMEPOS suppliers submit a claim during a span date already approved for the same beneficiary for a different DMEPOS supplier, the DME MAC shall deny the second or subsequent DMEPOS supplier's claim as a duplicate not a suspect duplicate when the following conditions are met:

- Same Beneficiary Medicare beneficiary identifier
- Overlapping span Date of Service (DOS) (From DOS and Through DOS)
- Same Healthcare Common Procedure Coding System (HCPCS) Code,
- Same Type of Service on the incoming claim matches a previously approved claim in history, and
- The item is a diabetic testing supply

- **Items Subject to Duplicate Editing**

    1. Diabetic Testing Supplies

120.3 - Suspect Duplicates
(Rev. 2678, Issued: 03-29-13, Effective: 04-29-13, Implementation: 04-29-13)

Suspect duplicates are claims or claim lines that contain closely-aligned elements sufficient to suggest that duplication may be present and, as such, require that the suspect claim be reviewed. Suspect duplicate edits can be hard coded in the system or local edits set up by Medicare contractors.

A. Criteria for Detecting Suspect Duplicates for Institutional Claims

A "suspect duplicate" claim is a claim being processed which, when compared to the history or pending file, begins with these characteristics:

- Match on the beneficiary information;
- Match on provider identification, and
- Same date of service or overlapping dates of service.

The contractors examine and compare to the prior bill any bill that is identified as a suspect duplicate. If the services (revenue or HCPCS codes) on a claim duplicate the services for the other, contractors should check the diagnosis. If the diagnosis codes are duplicates, obtain an explanation from the provider before making payment.

B. Suspect Duplicate Claims Submitted by Physicians and other Suppliers (including DMEPOS Claims)

The criteria for identifying suspect duplicate claims submitted by physicians and other suppliers are not published and vary according to the type of billing entity, type of item or service being billed, and other relevant criteria. The denial of claim as a duplicate of another claim may be appealed when the denial is based on criteria other than those specified above for exact duplication.

A/B MACs, Part B legacy contractors, and DME MACs must add an informational indicator to the Common Working File (CWF) transaction record when, as a result of a contractor audit/edit or CWF reject, the contractor examines what appears to be a duplicate item or service and approves it for payment.

130 - Adjustments and Late Charges

(Rev. 1, 10-01-03)
A3-3664, HO-411.1, HO-IM411.1, HH-445, A3-3610.8, HO-415.11

130.1 - General Rules for Submitting Adjustment Requests

(Rev.11794, Issued:01-19-23, Effective: 04-01-23, Implementation:04-03-23)

Adjustment requests are the most common mechanism for changing a previously accepted bill. They are required to reflect the results of QIO medical review. CMS may also require adjustments if it discovers that bills have been accepted and posted in error to a particular record. Adjustments that only recoup or cancel a prior payment are "credits" and must match the original in the following fields:

- Intermediary control number (ICN/DCN);
- Surname;
- Medicare beneficiary identifier

When a definite match cannot be made on the three fields above, the provider's MAC will use the fields below as needed. Note that for older claims, ICN/DCN probably will not match.

- Date of birth;
- Admission Date for inpatient, (Date of First Service for outpatient) unless changed by this adjustment requests; and
- From/thru dates for inpatient, (Date of First Service/Date of Last Service for Outpatient), unless changed by this adjustment request.

Cancel-only adjustment requests are not acceptable, except in cases of incorrect provider identification numbers and incorrect Medicare beneficiary identifier. The provider must submit a corrected replacement bill (bill type xx1) to its MAC after submitting the cancel-only request for the incorrect bill.

The provider must submit all other adjustment requests as debits only. It shows the ICN/DCN of the bill to be adjusted as described above, with the bill type shown as xx7. It submits adjustment requests to its MAC either electronically or on hard copy. Electronic submission is preferred. The ICN/DCN of an associated claim shall only be reported on adjustments. The MAC shall return to the provider any original claim reporting information in this field.

The MAC must enter the following bill types that relate to the entity generating the adjustment request:

xx7	Provider (debit)
xx8	Provider (cancel)
xxF	Beneficiary
xxG	CWF
xxH	CMS
xxI	MAC
xxM	MSP
xxP	QIO
xxJ	Other
xxK	OIG/GAO

The provider submits all adjustment requests as bill type xx7 or xx8. Since several different sources can initiate an MSP adjustment (e.g., the provider, CWF, or the MAC), the MSP designation, xxM, takes priority over any other source of an adjustment except OIG/GAO. When the provider submits an MSP adjustment request, the MAC will change the bill type to xxM. These priorities refer only to the designation of the source of the adjustment. The difference between CWF generating the adjustment request and CMS generating the adjustment request is: An adjustment request is CWF-generated if the MAC receives a CWF unsolicited response, alert or a CMS-L1002.

The MAC prepares an adjustment if instructed by CMS CO or CMS RO to make a change. Typically, such direction from CMS is to retroactively change payment for a class or other group of bills. Occasionally, CMS will discover an error in the processing of a single bill and direct the MAC to correct it.

If adjustments are rejected by CWF for additional corrections, they must be corrected and resubmitted. Even if a letter from CMS requests the adjustment action, the MAC must submit the adjustment request in its CWF record. If a rejected adjustment request is determined to be unnecessary, the MAC stops the adjustment action upon receipt of correction.

Where an adjustment request changes subsequent utilization, the MAC notes this and processes adjustments to subsequent bills if it services the provider.

130.1.1 - Adjustment Bills Involving Time Limitation for Filing Claims
(Rev. 1, 10-01-03)

A3-3664.D
If a provider fails to include a particular item or service on its initial bill, an adjustment request(s) to include such an item(s) or service(s) is not permitted after the expiration of the time limitation for filing a claim. However, to the extent that an adjustment request otherwise corrects or supplements information previously submitted on a timely claim about specified services or items furnished to a specified individual, it is subject to the rules governing administrative finality, rather than the time limitation for filing.

130.1.2 - Claim Change Reasons
(Rev. 1, 10-01-03)
HO-411.2, HO-IM411.2, HH-445

130.1.2.1 - Claim Change Reason Codes
(Rev. 4201, Issued: 01-18-19, Effective: 02-19-19, Implementation: 02-19-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

The provider submits one of the following claim change reason codes to its FI with each debit-only or cancel-only adjustment request:

Bill Type	Reason Code	Explanation
Xx7	D0 (zero)	Change to service dates
Xx7	D1	Change in charges
Xx7	D2	Change in revenue codes/HCPCS - HIPPS
Xx7	D3	Second or subsequent interim PPS bill - PPS inpatient hospital only
Xx7	D4	Change in GROUPER input (diagnoses or procedures) - PPS inpatient hospital).
Xx8	D5	Cancel-only to correct a Medicare beneficiary identifier or provider identification number
Xx8	D6	Cancel-only to repay a duplicate payment or OIG overpayment (includes cancellation of an outpatient bill containing services required to be included on the inpatient bill.)
Xx7	D7	Change to make Medicare the secondary payer
Xx7	D8	Change to make Medicare the primary payer
Xx7	D9	Any other change
Xx7	E0 (zero)	Change in patient status

The provider may not submit more than one claim change reason code per adjustment request. It must choose the single reason that best describes the adjustment it is requesting. It should use claim change reason code D1 only when the charges are the

only change on the claim. Other claim change reasons frequently change charges, but the provider may not "add" reason code D1 when this occurs.

The claim change reason code is entered as a condition code on the hard copy Form CMS-1450 or the electronic equivalent. For reason codes D0-D4 and D7-D9, the biller submits a debit-only adjustment request, bill type xx7. For reason codes D5 and D6, it submits a cancel-only adjustment request, bill type xx8.

130.1.2.2 - Edits on Claim Change Reason Codes

(Rev. 1, 10-01-03)

The following edits are based on the claim change reason code. The FI must apply them to each incoming adjustment request.

- If the type of bill is equal to xx7 and the claim change reason code is not equal to D0-D4, D7-D9, or E0, the FI rejects the request back to the provider with the following error message, "Claim change reason code must be present and equal to D0-D4, D7-D9, or E0 for a debit-only adjustment request."
- If the type of bill is equal to xx8 and the claim change reason code is not equal to D5-D6, the FI rejects the request back to the provider with the following error message, "Claim change reason code must be present and equal to D5-D6 for a cancel-only adjustment request."
- If the type of bill is equal to xx7 or xx8 and the ICN/DCN of the claim being adjusted is not present, the FI rejects the request back to the provider with the following message, "ICN/DCN of the claim being adjusted is required for an adjustment request."
- If more than one claim change reason code is present on the provider's request, the FI rejects the request back to the provider with the following message; "only one claim change reason code may apply to a single adjustment request from a provider. The FI chooses the single claim change reason code that best describes the reason for the provider's request and resubmit."
- If the provider submits an adjustment request as type of bill not equal to xx7 or xx8, the FI rejects the request back to the provider with the message, "Provider submitted adjustment request must use type of bill equal to xx7 or xx8."
- If the claim change reason code is equal to D0, the FI compares the beginning and ending dates on the provider's request to those on the claim to be adjusted on its history. If these dates are the same, it rejects the request back to the provider with the message, "Dates of service must change for claim change reason code D0."
- If the claim change reason code is equal to D1, the FI compares the total and line item charges on the provider's request to those on the claim to be adjusted on its history. If these changes are the same, the FI rejects the request back to the provider with the message, "Charges must be changed for claim change reason code D1."
- If the claim change reason code is equal to D2 (revenue code/HCPCS or HIPPS), the FI compares revenue codes/HCPCS or HIPPS on the provider's request to those on the claim to be adjusted on its history. If these codes are the same, it rejects the request back to the provider with the message, "Revenue codes/HCPCS or HIPPS must change for claim change reason code D2."

- If the claim change reason code is equal to D3 (PPS inpatient hospital only), the FI compares the ending date on the hospital's request to that on the claim to be adjusted on its history. If these dates are the same, it rejects the request back to the hospital with the message, "Thru dates must change for the claim change reason code D3."
- If the claim change reason code is equal to D4 (PPS inpatient hospital), the FI compares diagnosis and procedure codes on the provider's request to those on the claim to be adjusted on its history. If these codes are the same and are in the same sequence, it rejects the request back to the provider with the message, "Diagnoses and/or procedures must change for claim change reason code D4."
- If the claim change reason code is equal to D5 or D6, type of bill must be equal to xx8 on the provider's request. If type of bill is not equal to xx8, the FI rejects the request back to the provider with the message, "Type of bill must be equal to xx8 for claim change reason codes D5 or D6."
- If the claim change reason code is equal to D7, an MSP value code (12-16, 41-43, or 47) must be present, if a value code, 12-16, 41-43, or 47, is not present, the FI rejects the request back to the provider with the message, "An MSP value code (12-16, 41-43, or 47) must be present for claim change reason code D7."
- If the claim change reason code is equal to D7, and one or more of value codes 12-16, 41-43, and/or 47 is present but each value amount is equal to 0 (zero) or spaces, the FI rejects the request back to the provider with the message, "invalid value amount for claim change reason code D7."
- If the claim change reason code is equal to D8, and a value code 12-16, 41-43, or 47 is present, the FI rejects the claim back to the provider with the message, "Invalid value code for claim change reason D8."
- If the claim change reason code is equal to E0, the FI compares patient status on the provider's request to that on the claim to be adjusted. If patient status is the same, the FI rejects the request back to the provider with the message, "Patient status must change for claim change reason E0."

The FI must suspend for investigation all adjustment requests with claim change reason codes D8, and D9. Providers that consistently use D9 will be investigated and, if a pattern of abuse is evident, may be reported to the OIG.

130.1.2.3 - Additional Edits

(Rev. 1, 10-01-03)

The FI must perform the following additional edits and investigate adjustment requests the provider submits:

- A full denial once the bill is paid, except to accomplish retraction of a duplicate payment;
- Inpatient Hospital Only - A change in DRG based on a change in age or sex;
- A change in deductible;
- An adjustment request that changes a previously submitted QIO adjustment request;
- An adjustment of a bill due to a change in utilization or spell data on another bill;
- A reopening to change a no-payment bill to a payment bill;

- A reopening to pay a previously denied line item;
- An adjustment request the provider initiates with a claim change reason code equal to D7, with the Medicare payment amount equal to or greater that the previously paid amount; or
- An adjustment request with a claim change reason code equal to E0, and the claim is for an inpatient PPS hospital. The FI must investigate if the change is from patient status 02, transferred to another acute care facility.

130.1.3 - Late Charges

(Rev. 4201, Issued: 01-18-19, Effective: 02-19-19, Implementation: 02-19-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

The provider submits late charges on bills to the FI as bill type xx5. These bills contain only additional charges. However, if the late charge is for:

- Services on the same day as outpatient surgery subject to the ASC limit;

Services on the same day as services subject to OPPS;

- ESRD services paid under the composite rate;
- Inpatient accommodation charges;
- Services paid under HH PPS; and
- Inpatient hospital or SNF PPS ancillaries.

It must be submitted as an adjustment request.

The provider may submit the following charges omitted from the original paid bill to the FI as late charges:

- Any outpatient services other than the exceptions stated in this paragraph. This includes late charges for non-HH PPS services under Part B, hospice services other than the services of hospice-employed attending physicians, hospital outpatient services except those on the day of ambulatory surgery subject to the ASC payment limitation or the day of outpatient services subject to OPPS, RHC services, OPT services, SNF outpatient services, CORF services, FQHC services, CMHC services, ESRD services not included in the composite rate; and
- Any inpatient SNF ancillaries or inpatient hospital ancillaries other than from PPS providers. The provider may not submit late charges (xx5) for inpatient hospital or SNF accommodations. The provider must submit these as adjustments (bill type xx7).

The FI has the capability to accept xx5 bill types electronically and process them as initial bills except as described in the following paragraph.

The FI also performs the following edit routines on any xx5 type bills received:

- Pass all initial bill edits, including duplicate checks.
- Must not be for any of: Inpatient hospital or SNF PPS ancillaries, inpatient accommodations in any facility, services on the same day as outpatient surgery subject to the ASC payment limitation, services on the same day as services

subject to OPPS, or ESRD services included in the composite rate. These are rejected back to the hospital with the message, "This change requires an xx7 debit-only or xx8 cancel-only request from you. Late charges are not acceptable for inpatient PPS ancillaries, inpatient accommodations in any facility, services on the same day as outpatient surgery subject to the ASC payment limitation, services on the same day as services subject to OPPS, or ESRD services included in the composite rate."

- When an xx5 suspends as a duplicate, (dates of service equal or overlapping, provider ID equal, Medicare beneficiary identifier equal, and patient surname equal), the FI must determine the status of the original paid bill. If it is denied, the FI must deny the late charge bill.
- If an xx5 does not suspend as a potential duplicate, the FI rejects it back to the provider with the message, "No original bill paid. Please combine and submit a single original bill (xx1)."
- If the original bill was approved and paid, the FI compares the revenue codes on the original paid bill with the associated late charge bill:
    - For all providers (any bill type), if any are the same, and are revenue codes 41x, 42x, 43x, 44x, 63x, 76x, or 91x, the FI rejects the bill back to the provider with the message, "You must submit an adjustment (xx7) to the original paid bill. Revenue codes subject to utilization review are duplicated on the late charge bill."
    - For HHA services not under a plan of care (bill type 34x), the FI must apply the same logic for the following additional revenue codes. If any are the same and are revenue codes 27x, 29x, 55x, 56x, 57x, 58x, 59x, 60x, or 63x, the FI rejects the bill back to the provider with the message, "You must submit an adjustment (xx7) to the original paid bill. Revenue codes subject to utilization review are duplicated on the late charge bill."
    - For hospital outpatient services (bill type 13x only), the FI must apply the same logic for the following additional revenue codes. If any are the same and are revenue codes 255, 32x, 33x, 34x, 35x, 40x, 62x, 73x, 74x, 92x, or 943, the FI rejects the bill back to the hospital with the message, "You must submit an adjustment (xx7) to the original paid bill. Revenue codes subject to utilization review are duplicated on the late charge bill."
    - For RDFs (bill type 72x or 73x), the FI must apply the same logic for the following additional revenue codes; if any are the same and are revenue codes 634, 635, 82x, 83x, 84x, 85x, or 88x, the FI rejects the bill back to the provider with the message, "You must submit an adjustment (xx7) to the original paid bill. Revenue codes subject to utilization review are duplicated on the late charge bill."
- If the late charges bill relates to two or more "original" paid bills, and one of these is denied, the FI must suspend and investigate the late charge bill.
- The FI must compare total charges on the original paid bill with those on the associated late charge bill, and suspend and investigate any xx5 bill type with total charges in excess of those on the original paid bill. This edit suggests the provider may have rebilled the already paid services.

The FI may decide to perform additional edits on late charge bills.

130.2 - Inpatient Part A Hospital Adjustment Bills
(Rev. 4201, Issued: 01-18-19, Effective: 02-19-19, Implementation: 02-19-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

For adjustment requests reported as a claim record, the hospital must report the ICN/DCN of the original bill. See the ASC X12 Institutional Claim Implementation Guide for instructions for the electronic format and Chapter 25 for instructions for Form CMS-1450. Where payment is handled through the cost reporting and settlement processes, the hospital accumulates a log for those items not requiring an adjustment request. For cost settlement, the A/B MAC (A) pays on the basis of the log. This log must include:

- Patient name;
- Medicare beneficiary identifier;
- Dates of admission and discharge, or from and thru dates;
- Adjustment in charges (broken out by ancillary or routine service); and
- Any unique numbering or filing code necessary for the hospital to associate the adjustment charge with the original billing.

NOTE: Hospitals in Maryland, which are not paid under PPS or cost reports, submit an adjustment request for inpatient care of $500 or more, and keep a log as described above for lesser amounts. Because there are no adjustment requests, the A/B MAC (A) enters the payment amounts from the summary log into the PPS waiver simulation and annually pays the items on the log after the cost report is filed.

After cost reports are filed, the A/B MAC (A) makes a lump sum payment to cover these charges as shown on the summary log. The hospital uses the summary log for late charges only under cost settlement (outpatient hospital), except in Maryland.

Maryland and cost hospitals are required to meet the 12-month timeframe for timely filing of claims, including late charges.

For all adjustments other than QIO adjustments (e.g., provider submitted adjustments and/or those the A/B MAC (A) initiates), the A/B MAC (A) submits an adjustment request to CWF following its acceptance of the initial bill. To verify CMS's acceptance, the A/B MAC (A) can submit a status query.

Under inpatient hospital prospective payment, adjustment requests are required from the hospital where errors occur in diagnosis and procedure coding that changes the DRG, or where the deductible or utilization is affected. A hospital is allowed 60 days from the

date of the A/B MAC (A) payment notice (remittance advice) for adjustment requests where diagnostic or procedure coding was in error resulting in a change to a higher weighted DRG. Adjustments reported by the QIO have no corresponding time limit and are adjusted automatically by the A/B MAC (A) without requiring the hospital to submit an adjustment request. However, if diagnostic and procedure coding errors have no effect on the DRG, adjustment requests are not required.

Under PPS, for long-stay cases, hospitals may bill 60 days after an admission and every 60 days thereafter if they choose. The A/B MAC (A) processes the initial bill through Grouper and PRICER. When the adjustment request is received, it processes it as an adjustment. In this case, the 60-day requirement for correction does not apply.

130.2.1 - Tolerance Guidelines for Submitting Inpatient Part A Hospital Adjustment Requests

(Rev. 1, 10-01-03)

A3-3664.1.A

When a bill is submitted and the hospital or the FI discovers an error, the hospital submits an adjustment request using the CMS-1450, if the error is a change in the:

- Number of inpatient days (including a change in the length of stay, or a different allocation of covered/noncovered days);
- Blood deductible;
- Inpatient cash deductible of more than $1;
- Servicing hospital;

For inpatient hospital bills paid under PPS, CMS also requires an adjustment request for a change in:

- Discharge status in a PPS hospital;
- The DRG code; or
- Outlier payment amount.

The hospital submits most adjustment requests as debits, using bill type xx7.

Also, it submits a debit-only adjustment request to the FI if it previously submitted an interim bill for a PPS hospital stay or wishes to change the number of days in any inpatient stay.

The FI then submits the adjustment to CWF. An adjustment from the QIO for any of the above also requires a submission to CMS via CWF.

If an adjustment the hospital initiates results in a change to a higher weighted DRG, the FI edits the adjustment request to insure it was submitted within 60 days of the date of the remittance for the claim to be adjusted. If it is, the FI processes the claim for payment. If the remittance date is more than 60 days prior to the receipt date of the adjustment request and results in a change to a lower weighted DRG, the FI processes the claim for payment and forwards it to CWF.

130.3 - SNF Part A Adjustments

(Rev. 1, 10-01-03)

130.3.1 - Tolerance Guides for Submitting SNF Inpatient Adjustment Requests

(Rev. 4201, Issued: 01-18-19, Effective: 02-19-19, Implementation: 02-19-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

SNF inpatient adjustment requests adhere to the same billing instructions as non-inpatient adjustment requests with the following changes. When an initial bill has been submitted and the provider or FI discovers an error on the bill, an adjustment request is submitted if the change involves one of the following:

- A change in the Part B cash deductible of more than $1.00
- A change in the number of inpatient days;
- A change in the blood deductible;
- A change in provider number;
- A change in coinsurance which involves an amount greater than $1.99;
- A change in the HIPPS code to correct a data input error or,
- Effective for changes for services June 1, 2000, change in HIPPS code due to an MDS correction. (Such adjustments are required within 120 days of the through date on the initial bill.) **NOTE:** See Chapter 6, Section 35 for information on submitting adjustments to HIPPS codes resulting from MDS corrections.

Late charge billings (type of bill xx5) are not acceptable for SNF PPS Part A services. The reason for an adjustment (Claim Change Reasons) is reported in one of the condition code fields. Claim Change Reason Codes applicable to SNFs are:

D0	Changes to Service Dates	D6	Cancel only to repay a duplicate OIG payment
D1	Changes to Charges	D7	Change to Make Medicare Secondary Payer
D2	Changes in Revenue codes/ HCPCS - HIPPS	D8	Change to Make Medicare Primary Payer
D4	Changes in Grouper code	D9	Any Other Change
D5	Cancel to correct Medicare beneficiary identifier or Provider ID	E0	Change in Patient Status

The SNF selects the one code that best describes the change reason. An adjustment may contain multiple changes even though only one reason code is reported.

130.3.2 - SNF Inpatient Claim Adjustment Instructions
(Rev. 1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

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

2. Internal Control Number (ICN)/Document Control Number (DCN) Required. All providers requesting an adjustment to a previously processed claim must insert the ICN/DCN of the claim to be adjusted. Payer A's ICN/DCN must be shown on line "A". Similarly, the ICN/DCN for Payer's B and C must be shown on lines B and C respectively.

3. Appropriate Claim Change Reason Code.

4. The provider must submit an entire replacement debit.

Note: Information regarding the form locator numbers that correspond to these data element names and a table to crosswalk UB-04 form locators to the 837 transaction is found in Chapter 25.

130.3.3 - Patient Does Not Return From SNF Leave of Absence, and Last Bill Reported Patient Status as Still Patient (30)
(Rev. 1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

Where the patient does not return from a leave of absence, regardless of the reason, the SNF must submit a discharge bill showing the date of discharge as the date the individual actually left. If the patient status was reported as "30" (still patient) on an interim bill and the patient failed to return from a leave of absence within 30 days, including the day leave began, or has been admitted to another institution at any time during the leave of absence, the SNF must submit an adjustment request to correctly indicate the day the patient left as the date of discharge. (A beneficiary cannot be an inpatient in two institutions at the same time.) This closes the open admission on the patient's utilization record.

NOTE: Home health or outpatient services provided during a leave of absence do not affect the leave and no discharge bill is required.

EXAMPLE l:

The beneficiary goes on a leave of absence on January 3, expecting to return on January 10. On January 6, the SNF receives word that the patient died on January 5. The SNF submits a discharge bill showing January 3 as the date of discharge.

EXAMPLE 2:

The beneficiary goes on a leave of absence on February 6, expecting to return on February 12. However, the beneficiary does not return on February 12 as expected and the SNF cannot determine whether the beneficiary will return. The SNF submits a discharge bill showing February 6 as the date of discharge as soon as practical, or after 30 days have elapsed from the day the leave began. If an interim bill had been submitted showing the beneficiary in "still patient" status as of February 6 or later, the SNF submits an adjustment request showing February 6 as the discharge date. The advantage of delaying the discharge bill for 30 days is that it will make unnecessary a new admission notice in the event the beneficiary returns before 30 days have elapsed.

EXAMPLE 3:

The beneficiary goes on a leave of absence on March 4, and is expecting to return April 1 but does not. The SNF submits a discharge bill showing March 4 as the date of discharge since the beneficiary did not return within the 30-day period.

130.4 - Hospital and SNF Part B Adjustment Requests
(Rev. 1, 10-01-03)

130.4.1 - Guidelines for Submitting Adjustment Requests
(Rev. 1, 10-01-03)

SNF-562, SNF-562.A

When an initial bill for outpatient services or inpatient Part B services has been submitted and the provider or the FI discovers an error, the provider submits an adjustment request to the FI. The FI submits the adjustment to CMS if there is a change in:

- The Part B cash deductible of more than $1;
- Covered charges of more than $1 on bills for surgery or other outpatient procedures;
- The servicing provider;
- The Part B blood deductible;
- The coinsurance amount greater than $1.99; or
- Procedure codes.

130.5 - Home Health Adjustments
(Rev. 13089; Issued: 02-21-25; Effective: 05-22-25; Implementation: 05-22-25)

Several conditions can cause the claim for a HH period of care (Type of Bill 032x) to be adjusted. Claims may be cancelled (TOB 0328) by HHAs if a mistake is made in billing. In these cases, the period of care will be cancelled in CWF as well. Adjustment claims (TOB 0327) may also be used to change information on a previously submitted claim, which may also change payment.

A home health agency submits a corrected claim if any of the following apply (the list is not exhaustive):

- A change in provider number;
- A change in visits (decrease or increase);
- A change in diagnosis code or other claim elements affecting the determination of the HIPPS code used for payment; or

- A change in the patient status code affecting payment of the claim or the ability of other providers subject to HH consolidated billing to be paid for covered services.

Diagnosis codes on HH claims reflect the patient's condition as of the start of a period of care (the claim From date). Errors in diagnosis codes which applied on the From date of a given period of care may be corrected with an adjustment claim. The HHA reports condition code D4 on the adjustment claim. Diagnosis codes that reflect a change in the patient's condition during a period of care should be reflected on the claim for the next period.

An HHA may submit a claim with patient status code 30 (still patient) at the end of a period of care on the expectation that additional HH visits will be provided in the next period of care. Some intervening event may prevent the delivery of additional visits and the beneficiary is subsequently discharged. In this situation, the HHA shall submit an adjustment claim to correct the patient status code to reflect the discharge on their claim, since patient status code 30 may prevent billing of services subject to HH consolidated billing during the last days of the period of care. The HHA reports condition code E0 (zero) on the adjustment claim.

130.6 - Adjustments to Reprocess Certain Claims Denied Due to an Open Common Working File (CWF) Medicare Secondary Payer (MSP) Group Health Plan (GHP) Record Where the GHP Record Was Subsequently Deleted or Terminated

(Rev. 4201, Issued: 01-18-19, Effective: 02-19-19, Implementation: 02-19-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

Group Health Plan (GHP) Medicare Secondary Payer claims were not reprocessed automatically in situations where Medicare becomes the primary payer after an MSP GHP record was deleted, or when an MSP GHP record was terminated, after claims were processed subject to the CWF record. It was the responsibility of the beneficiary, provider, physician or other supplier to contact the Medicare contractor and request the denied claims be reopened when reopening was permitted. This was a burden on the beneficiary, physician, or other supplier. This instruction directs CWF to implement an automated process to reopen certain MSP claims when MSP GHP records were 1) deleted, or 2) under some circumstances, certain MSP GHP records were terminated and claims were denied (rejected for Part A claims) due to MSP or Medicare made a secondary payment before the termination date was accreted.

The COBC currently identifies, deletes, and terminates MSP GHP records on the CWF when appropriate. The 1-800 Medicare also applies simple terminations to MSP GHP working aged records only. Upon deletion of an MSP record, or where a termination dated added to an MSP GHP (MSP Codes 12, 13, 43) record, this instruction directs the CWF to search the claims history for claims, with dates of service within 180 days of the deletion date, or the date the termination date was applied, which were processed for secondary payment or were denied because of the MSP edit as set forth in 42 CFR 405, subpart G, H and I. The Shared Systems shall reopen these claims, as necessary, including locating any claims billed to Medicare as primary, or secondary, and denied (rejected for Part A claims) on the basis of the subsequently deleted CWF MSP GHP record. Claims with added termination dates shall be reopened no earlier than the termination date applied to CWF.

The CWF shall generate an unsolicited response "W" and send this response with the 24 and 10 trailers containing the identifying information regarding any such claims found to the shared system. The unsolicited response shall include all the necessary information to identify the claim(s), including the Document Control Number/Internal Control Number/Claim Control number, Medicare beneficiary identifier, beneficiary name, and date(s) of service. The CWF electronically transmits this unsolicited response to the claims processing contractor(s) that originally processed the claim(s) or send the claim to the MAC contractor that assumed the workload for the original legacy contractor that processed the claim. The previously denied claim(s) (rejected for Part A) is not to be canceled and remains on the CWF claims history pending subsequent adjustment as warranted.

Upon receipt of the unsolicited response, the shared system software reads the claim information in the trailer for each claim and performs an automated reopening to each claim. The claim(s) must be reopened and adjusted as warranted for all non-reimbursed/claim denials (part A rejections)/ where Medicare paid secondary or terminations that were based upon the MSP GHP record that was just deleted or terminated. The MSP unsolicited responses are reported with the current MSP responses when COB deletes an MSP record a "03" will be received. The shared systems release the adjusted claims. Adjustments are subject to all applicable edits as the original claim(s) and sent to the CWF so that the claim(s) on the CWF history are replaced with the adjusted claim(s) records.

The automated MSP GHP reprocessing requirement allows CWF to alert the shared system when a MSP GHP record is deleted or a termination date added for specific beneficiaries. The shared systems and Medicare Contractors receive an IUR transaction response from CWF alerting the system to reprocess certain MSP GHP claims where the open GHP record was deleted /terminated by the Coordination of Benefits Contractor (COBC) or 1-800-Medicare. This unsolicited transaction is sent to the contractors on record at CWF who had claim history for the associated beneficiary within the 180 day period. The CWF system is already programmed to send an updated MSP transaction (HUSC transaction) any time a change is made to an MSP record and this process does not change.

130.7 - MAC Guidance Related to Use of Adjustment Codes on Adjustment Claims

(Rev. 4415; Issued: 10-11-19; Effective: 01-01-20; Implementation: 01-06-20)

The Centers for Medicare & Medicaid Services (CMS) is refining the claim adjustment reporting process to achieve better consistency in the reporting of claim adjustments across the Medicare Administrative Contractors (MACs) and is adding new codes to address gaps in the current list of codes available.

The Shared Systems use different terminology for the adjustment codes. In FISS, the adjustment codes are called Claim Frequency Codes. In MCS, the adjustment codes are called Method of Discovery Codes. In VMS, the adjustment codes are called Accounting Discovery Codes.

CMS is directing the A/B MACs to use claim frequency code "H" when CMS initiates the Part A claim adjustment, such as a mass adjustment directed by CMS to address system issues, and claim frequency code "I" when the A/B MAC identifies and initiates the Part A claim adjustment.

CMS is also creating a new method of discovery code "12" to identify Part B adjustments in MCS that were initiated by CMS, and a new method of discovery code "13" for MAC initiated Part B adjustments in MCS. The A/B MACs should use method of discovery code "12" for CMS-directed adjustments that do not fall into the "C" - CMS Review category or other existing CMS-related method of discovery categories. The A/B MACs should use method of discovery code "13" for MAC identified and initiated adjustments that do not fall into the existing method of discovery code categories, such as method of discovery code "A". The A/B MACs should use method of discovery code "A" for adjustments arising from MAC initiated internal review, such as adjustments to address errors the MAC identified while processing the claim or adjustments due to MAC internal quality reviews.

For provider initiated adjustments, MACs should continue with their current method of reporting (claim frequency code "7" for Part A claims, method of discovery code "P" for Part B MCS claims, and accounting discovery code "D" for Part B DME claims).

140 - Fiscal Intermediary (FI) Edits Affecting Multiple Bill Types

(Rev. 620, Issued: 07-29-05, Effective: 01-03-06, Implementation: 01-03-06)

140.1 - Threshold Edit for Outpatient and Inpatient Part B Claims

(Rev. 620, Issued: 07-29-05, Effective: 01-03-06, Implementation: 01-03-06)

Effective for claims received on or after January 1, 2006, intermediaries shall edit for outpatient and inpatient Part B claims that meet or exceed a reimbursement amount of $50,000. The edit shall be applied to the following providers and bill types:

Provider Type	Types of Bills
• Hospitals	12X, 13X, 14X
• Skilled Nursing Facilities	22X, 23X
• Home Health Agencies	32X, 33X, 34X
• Religious Nonmedical Health Care Institutions	43X
• Rural Health Clinics	71X
• Renal Dialysis Facilities	72X
• Federally Qualified Health Centers	73X
• Outpatient Rehabilitation Facilities	74X
• Comprehensive Outpatient Rehabilitation Facilities	75X
• Community Mental Health Centers	76X
• Hospice Providers	81X, 82X
• Non-OPPS Hospitals Ambulatory Surgery	83X
• Critical Access Hospitals	85X

The FIs shall suspend those claims receiving the threshold edit for development and contact providers to resolve billing errors. If the FI determines that the reimbursement is excessive and claim corrections are required, the FI shall return the claim to the provider. If the FI determines that the billing is accurate and the reimbursement is not excessive, the FI shall override the edit and submit the claim to the Common Working File (CWF)

140.2 – Systematic Validation of Claims Information Using Patient Assessments

(Rev. 3001, Issued: 08-01-14, Effective: 10-01-12, Implementation: 01-05-15)

The case-mix groups used to determine payments under several Medicare prospective payment systems (PPS) are based on clinical assessments of the beneficiary. Each payment system uses a different patient assessment tool:

Payment System	Assessment Used
Skilled Nursing Facility – SNF PPS	Minimum Data Set
Home Health – HH PPS	Outcomes and Assessment Information Set
Inpatient Rehabilitation Facility – IRF PPS	IRF Patient Assessment Instrument

In all three payment systems, the assessments are entered into software at the provider site that encodes the data into a standard transmission format and transmits the assessments to quality improvement systems. In addition, the software runs the data from the assessments through grouping software that generates a case-mix group to be used on Medicare PPS claims. These case mix groups are reported on claims using a Health Insurance PPS (HIPPS) code.

CMS provides free grouping software to perform this function, but many providers create their own software due to their need to integrate these data entry and grouping functions with their own administrative systems. In some cases, this results in HIPPS codes reported on claims that differ from the HIPPS code calculated by the assessment system.

In the interest of payment accuracy, Medicare claims processing systems may temporarily hold Medicare PPS claims paid under these payment systems (Medicare Advantage claims are excluded), in order to validate the claim information against the assessment record. If the information found in the assessment system differs from the claim information, the assessment information will be used to pay the claim. This process will occur within the payment floor period.

This process may be used for various purposes, including:

- Validating the provider-submitted HIPPS code
- Ensuring timely assessment submission requirements are met
- Ensuring conditions of payment are met.

140.3 - Verification Edit for Claims with OPPS Payments
(Rev. 2463, Issued 05-04-12, Effective: 10-01-12, Implementation: 10-01-12)

Effective for claims received on or after October 1, 2012, FISS shall install a verification edit for claims with OPPS payments that exceed a reimbursement amount greater than submitted charges. The edit shall be applied to the following providers and bill types:

Provider Type	**Types of Bills**
Hospitals	12X, 13X, 14X

Contractors shall suspend those claims receiving the verification edit for development and contact providers to resolve billing errors. If the contractor determines that the reimbursement is excessive and claim corrections are required, the contractor shall return the claim to the provider. If the contractor determines that the billing is accurate and the reimbursement is not excessive, the contractor shall override the FISS edit and submit the claim to the Common Working File (CWF).

150 - Limitation of Liability Notification and Coordination With Quality Improvement Organizations (QIOs)
(Rev. 13026, Issued: 12-27-24, Effective: 10-11-24, Implementation: 02-15-25)

The longstanding relationship between QIOs and A/B MACs (A) is defined in regulations at 42 CFR 476.80. Generally, these regulations require QIOs and A/B MACs (A) to have an agreement under which:

- QIOs inform A/B MACs (A) of the results of DRG validation of hospital inpatient claims
- QIOs inform A/B MACs (A) of initial determinations of cases subject to preadmission review and any changes to these determinations
- A/B MACs (A) ensure they do not pay claims subject to initial determinations until they receive notice from the QIO
- QIOs and A/B MACs (A) exchange data or information and otherwise coordinate to perform their functions.

Additionally, this relationship has expanded over time to include:

- Regulations regarding expedited determinations of discharges, found in 42 CFR 405, sections 1200-1208.
- Regulations regarding expedited determinations based on Medicare Change of Status Notifications (MCSNs), found in 42 CFR 405, sections 1210-1212.

The following subsections provide additional detail on the coordination between these parties. They also describe how various Medicare provider types reflect decisions of QIOs on claims they submit to Medicare A/B MACs (A) and how these decisions may affect the liability of Medicare beneficiaries for payment.

150.1 - Limitation on Liability - Overview

(Rev. 632, Issued: 07-29-05, Effective: 01-03-06, Implementation: 01-03-06)
A3-3674.1
HO-414.6

Chapter 30, of this manual has a complete explanation of the limitation of liability provision. However, the basic premise of the limitation on liability provision (§1879 of the Act) is that beneficiaries and providers who "did not know, and could not reasonably have been expected to know, that payment would not be made for such items(s) or service(s) item(s) and/or service(s)" are protected from liability. Where the provider had such knowledge, such that the 1879 limitations on liability do not apply, liability falls upon the provider (i.e., the provider cannot charge the beneficiary for such services when aware no program payment will be made).

Medicare requires providers to notify beneficiaries when they face financial liability, so they can make informed choices.

150.2 - Hospital Claims Subject to Hospital Issued Notices of Noncoverage

(Rev. 632, Issued: 07-29-05, Effective: 01-03-06, Implementation: 01-03-06)

Hospitals must issue the HINN for inpatient hospital services, form prior to delivering care, and must deliver the form properly, so that a beneficiary knowingly assumes liability. Instructions for the HINN are found in CMS Transmittal 594, and apply in specific cases to Part A services furnished by hospitals.

150.2.1 - Scope of Issuance of Hospital Issued Notices of Noncoverage (HINNs)

(Rev. 632, Issued: 07-29-05, Effective: 01-03-06, Implementation: 01-03-06)
HO-414.3, .4

Inpatient hospitals are required to issue HINNs to beneficiaries in a variety of circumstances defined in Chapter 30 of this manual. Hospitals should refer to section 80 of that chapter for further instructions on HINNs.

NOTE: Hospitals submit bills for all inpatient stays, including those for which no payment can be made. Although no monies are involved with no-payment bills, a claim is required because hospitalization could extend a Medicare beneficiary's benefit period, or coinsurance or deductible may be due. The hospital is not required to issue a HINN when it does not plan to bill the beneficiary (or their representative) for item(s) or service(s). However, applicable coinsurance and deductibles are always charged to the beneficiary when care is provided no matter what party is liable for payment, and no liability notification is required for these collections.

150.2.2 - General Responsibilities of QIOs and A/B MACs (A) Related to HINNs

(Rev. 13026, Issued: 12-27-24, Effective: 10-11-24, Implementation: 02-15-25)

Publication 100-10, The Quality Improvement Organization Manual, Chapter 7, provides detailed instructions regarding QIO responsibilities and procedures related to HINNs.

The A/B MAC (A) is responsible for making liability determinations in other cases (e.g., eligibility and reductions of payment). However, the A/B MAC (A) adjudicates claims, makes payment and sends beneficiaries Medicare Summary Notices in all cases, reflecting both QIO and A/B MAC (A) determinations on liability. This joint responsibility requires that the QIO notify the A/B MAC (A) of its denial determinations, all preadmission determinations, and diagnostic or procedural coding changes. The A/B MAC (A) does not issue a denial notice to the beneficiary or the hospital for cases that have been reviewed by the QIO. The QIO notifies the beneficiary and hospital.

NOTE: QIO determinations are binding and cannot be reversed by the A/B MAC (A).

150.2.3 - Billing and Claims Processing Requirements Related to HINNs
(Rev. 13026, Issued: 12-27-24, Effective: 10-11-24, Implementation: 02-15-25)

Where QIO review is done prior to billing (preadmission or admission HINN), the hospital reports the results of the QIO's review on the claim using special indicators. A set of condition codes were created to reflect these reviews. These condition codes, C1-C7, are known as the QIO approval indicator codes.

The A/B MAC (A) reviews these condition codes and makes determinations as follows:

- Code C1, C3, or C6 - Pay as billed.
- Code C4 - Do not pay, but process a no-payment bill.
- Blank or Code C5 - Return the claim to the provider for QIO review, unless the A/B MAC (A)'s agreement with the QIO requires sending it directly to the QIO.

Where the QIO review occurs after A/B MAC (A) processing (postpayment review), the QIO reports adjustments to the A/B MAC (A). Currently there is no approved electronic format for this report.

150.3 - Skilled Nursing Facility (SNF), Home Health Agency (HHA), Hospice and Comprehensive Outpatient Rehabilitation Facility (CORF) Claims Subject to Expedited Determinations
(Rev.13026, Issued: 12-27-24, Effective: 10-11-24, Implementation: 02-15- 25)

In short, SNFs, HHAs, hospices and CORFs must give notice to Medicare beneficiaries of their right to expedited determinations when their period of covered care ends. Expedited determinations allow beneficiaries to challenge/appeal their provider's decisions to discharge, whereas the standard appeal process available after a claim is adjudicated allows beneficiaries to dispute payment denials. Detailed instructions regarding expedited determination notices are found in chapter 30, section 260.

150.3.1 - Scope of Issuance of Expedited Determination Notices
(Rev. 632, Issued: 07-29-05, Effective: 01-03-06, Implementation: 01-03-06)

Expedited determination notices are required prior to discharge when Medicare covered care has been occurring for some type of duration, such as a stay in an inpatient facility, or a period of services delivered under a plan of care supported by a physician order. Generally, intermittent items or services covered under Part B do not trigger the right to expedited determinations, since there is no continuous care to end. Expedited determinations are available to beneficiaries for each of the specified provider types as follows:
HHAs: Provider initiated discharges for coverage reasons from HH services under a home health plan of care (types of bill 32x and 33x) are subject to expedited determination notices. Home health services billed on a 34x type of bill are included if there is a therapy plan of care, but not when the HHA is acting as a durable medical equipment supplier in one-time or sporadic delivery of equipment.

SNFs: Provider initiated discharges for coverage reasons associated with SNF and swing bed inpatient claims (types of bill 18x, 21x and 22x) are subject to expedited determination notices.
Hospices: Provider initiated discharges for coverage reasons from hospice services (types of bill 81x and 82x), whether in inpatient or home care settings, are subject to expedited determination notices. Even though revocation represents an end of covered hospice care, it cannot trigger an expedited determination since it is the beneficiary's, not the provider's, choice to revoke. Hospice discharges related to qualification/coverage specific to the benefit would be rare cases where a beneficiary previously certified as terminally ill is judged no longer to be terminal.
CORFs: Provider initiated terminations of all covered CORFs services (type of bill 75x) provided under a therapy plan of care are subject to expedited determination notices. CORF services not provided under a plan of care, such as injections, are not included. Therapy services provided by outpatient rehabilitation facilities (type of bill 74x) or therapy services in hospital outpatient departments are not included.
Expedited determinations notices are not required when discharge is unrelated to coverage.

150.3.2 - General Responsibilities of QIOs and A/B MACs (A) Related to Expedited Determinations

(Rev.13026, Issued: 12-27-24, Effective: 10-11-24, Implementation: 02-15- 25)

A. QIO Role

QIOs review expedited determination notices providers give beneficiaries, both as part of making decisions relative to coverage and to assure providers have given valid notice. The QIO is responsible for establishing contact with the provider, so that the beneficiary's medical records can used in making a determination, although QIOs can still make such decisions even if records are not available. The QIO makes a decision on coverage in answer to the beneficiary's request for review, relaying this decision back to the involved parties. If the beneficiary does not accept the QIO determination, they may request a reconsideration from a Qualified Independent Contractor (QIC).

B. A/B MAC (A) Role

A/B MACs (A) support beneficiaries and providers through an awareness of the expedited determination process and by performing routine duties potentially affected by this process--liability notice oversight, claims processing and medical review.

A/B MAC (A) medical review should never repeat or contradict the results of QIO review regarding coverage, since this would be duplicative and QIO decisions are binding, and QIOs are bound by the same coverage policy in making their determinations--even local policy. But the scope of these QIO decisions is limited to discharge, and medical review examines a much broader range of potential issues and periods of care. For example, a monthly SNF claim could include a discharge reviewed by a QIO, but it also contains other days of billing not related to discharge—the non-

discharge period is not considered by the QIO, and would still be subject to medical review.

150.3.3 - Billing and Claims Processing Requirements Related to Expedited Determinations

(Rev.13026, Issued: 12-27-24, Effective: 10-11-24 , Implementation: 02-15- 25)

As noted above, the outcome of expedited determinations and reconsiderations will be reported on Medicare claims to assure A/B MAC (A) adjudication of claims is consistent with QIO/QIC decisions. Note that the expedited review process is always completed prior to billing, and therefore does not directly affect established billing procedures, even demand billing, other than the use of indicators described below.

Special indicators are used on claims to reflect the outcome of QIO expedited determinations and QIC reconsiderations. Before the creation of the expedited review process, QIO related determinations were reflected only on hospital claims. A set of condition codes were used to reflect these determinations. These codes, C1- C7, are known as the QIO approval indicator codes.

With the advent of the expedited determination process, these QIO approval indicators are relevant to types of bill other than inpatient hospital claims. The QIO approval indicator codes described below are valid for Medicare billing on the following types of bill:

18x, 21x, 22x, 23x, 32x, 33x, 34x, 75x, 81x, 82x.

Since QIO expedited decisions and QIC reconsideration decisions have the same effect on providers and beneficiaries, the same QIO approval indicator codes will be used to report a decision by either entity. Providers should note that no indicators are required on discharge claims in the case where a generic notice is provided and the beneficiary does not request an expedited determination.

A Reporting of QIO/QIC Decisions Upholding a Discharge

Providers must also report indicators on claims when they receive notification of decisions which uphold the provider's decision to discharge the beneficiary from Medicare covered care. In these cases, providers submit a discharge claim for the billing period that precedes the determination according to all applicable claims instructions plus one additional data element. Providers must annotate these claims with condition code C4, defined as "Services Denied."

Beneficiaries are protected from liability for the period from the delivery of the expedited notice, usually two days before the end of coverage, to the end of the covered period written on the notice if the beneficiary requests an expedited determination timely. If the beneficiary does not request the determination timely, or if the determination process at

the QIO is delayed, the beneficiary may be liable for services provided from the day after the end of the covered period until the date of the actual discharge.

In cases where the beneficiary may be liable, in addition to reporting condition code C4 providers must also report occurrence span code 76, defined as "patient liability period," along with the days of liability that have been incurred. Line items with dates of service falling within this patient liability period are reported with noncovered charges and, if they require HCPCS coding, with modifier –TS. A/B MAC (A) will deny these lines and hold the beneficiary liable.

In certain cases, an Advance Beneficiary Notice (ABN) may be issued simultaneously or immediately following the issuance of an expedited determination notice. These ABNs would pertain to continued services that the beneficiary wishes to receive despite the provider's intent to discharge the beneficiary. Any required physician orders continue to be needed for the services to continue. If these ABN situations result in a beneficiary's request for a demand bill to Medicare regarding continuing services after the QIO/QIC has upheld the discharge, providers must report condition code C4 on the demand bill. The demand bill must otherwise be prepared according to all other applicable instructions.

B Reporting of QIO/QIC Decisions Not Upholding a Discharge

When providers are notified of QIO/QIC decisions that authorize continued Medicare coverage and do not specify a coverage ending date, they must submit a continuing claim for the current billing or certification period according to all claims instructions for the applicable type of bill, plus a single additional data element. Providers must annotate these claims with condition code C7, which is defined "QIO extended authorization." This indicator will alert A/B MAC (A) that coverage of the services on the claim has already been subject to review.

In the circumstance, expected to be rare, when providers are notified of QIO/QIC decisions which authorize continued Medicare coverage only for a limited period of time, they must submit claims as follows:

- If the time period of coverage specified by the QIO/QIC extends beyond the end of the normal billing or certification period for the applicable type of bill, providers submit a continuing claim for that period according to all applicable claims instructions plus two additional data elements. Providers must annotate these claims with condition code C3, which is defined "QIO partial approval" and with occurrence span code M0, which is defined "QIO approved stay dates", along with the following dates—the beginning date of the coverage period provided by the QIO/QIC, and the statement through date of the claim.

- If the time period of coverage specified by the QIO/QIC does not extend to the end of the normal billing or certification period for the applicable type of bill, providers submit a discharge claim according to all applicable claims instructions plus two

additional data elements. Providers must annotate these claims with condition code C3, which is defined "QIO partial approval" and with occurrence span code M0, which is defined "QIO approved stay dates" and the dates provided by the QIO/QIC.

NOTE: Regarding any decision that does not uphold a discharge, QIO/QIC decisions authorizing extended coverage cannot authorize delivery of services if there are not also the required physician orders needed to authorize the care.

C Billing Beneficiaries in Cases Subject to Expedited Determinations

Providers should note a significant difference between the use of expedited determination notices and the use of ABNs. As described in Claims Processing Manual, Chapter 1, section 60.3.1, in ABN or HHABN situations, all providers other than SNFs can bill beneficiaries for services subject to a demand bill while awaiting a Medicare determination on the coverage of the services. The same is not true in expedited determination situations. When a beneficiary requests an expedited determination timely, no funds may be collected until the provider receives notification of the QIO/QIC decision.

D Reporting Provider Liability Situations

Providers may be liable as a result of two specific situations in the expedited review process:

(1) if the provider is not timely in giving information to the QIO; and

(2) if the provider does not give valid notice to the beneficiary.

Since both these events occur after the point the provider has already determined discharge is imminent, there may be no actual liability, since there may be no medical need for additional care. However, if services are required, and either of these liability conditions apply, such services should be billed as noncovered line items using the –GZ modifier, which indicates the provider is liable, consistent with Section 60.4.2 of this chapter.

150.4 - General Responsibilities of QIOs and A/B MACs (A) Related to Expedited Determinations Based on Medicare Change of Status Notifications (MCSNs)

(Rev. 13026, Issued: 12-27-24, Effective: 10-11-24 , Implementation: 02-15- 25)

This section provides claims processing instructions to implement an expedited hospital status change appeals process required by final rule, CMS-4204-F.The resulting regulations are located at 42 CFR Part 405.1210 through 405.1212.

Expedited hospital status change appeals are afforded to certain beneficiaries in Original Medicare only who were initially admitted to a hospital as an inpatient by a physician but whose status during their stay was changed to an outpatient receiving observation services by the hospital's utilization review committee (URC) (thereby effectively denying Part A coverage for their hospital stay), and meet other conditions specified in the court order. Regulations at 42 CFR 405.1210(b) require hospitals to notify beneficiaries of their right to pursue an appeal regarding the decision to reclassify the beneficiary from an inpatient to an outpatient receiving observation services. The Medicare Change of Status Notice (CMS-10868) is the standardized notice to satisfy the notification requirement.

After receipt of the MCSN, eligible beneficiaries are given the opportunity to appeal, and may argue that their inpatient admission satisfied the relevant criteria for Part A coverage and that the hospital URC's determination to reclassify the beneficiary as an outpatient receiving observation services was therefore erroneous. The change in status from inpatient to outpatient may also affect coverage of the beneficiary's post-hospital extended care services furnished in a skilled nursing facility (SNF).

A. QIO Role

Once an eligible beneficiary has requested an appeal, the QIO reviews the records from the hospital relative to the change in status, and verifies that the provider has given valid notice. The QIO is responsible for establishing contact with the provider, so that the beneficiary's medical records can used in making a determination, although QIOs can still make such decisions even if records are not provided. The QIO makes a decision on coverage in answer to the beneficiary's request for review of their change in status, relaying this decision back to the beneficiary or their representative, as well as the hospital. If the beneficiary does not agree with the QIO determination, they may request that the QIO conduct a reconsideration.

B. A/B MAC (A) Role

A/B MACs (A) support beneficiaries and providers through an awareness of the expedited determination process and by performing routine duties potentially affected by this process--liability notice oversight, claims processing and medical review.

A/B MAC (A) medical review should never repeat or contradict the results of QIO review regarding the change of status of the hospital claim, since this would be duplicative and QIO decisions are binding. But the scope of these QIO decisions is limited to the change in status, and medical review examines a much broader range of potential issues and periods of care. For example, a monthly SNF claim may follow a change of status reviewed by a QIO, but it also contains other days of billing that are subject to additional coverage criteria. Other issues not considered by the QIO may still be subject to medical review.

150.4.1- Billing and Claims Processing Requirements Related to Expedited Determinations Following Appeal of Status Change s

(Rev.13026, Issued: 12-27-24, Effective: 10-11-24, Implementation: 02-15- 25)

The outcome of expedited determinations and reconsiderations based on appeals of hospital status changes are reported on Medicare claims to assure A/B MAC (A) adjudication of claims is consistent with QIO decisions. Note that the expedited review process for timely submitted appeals is completed prior to billing, and therefore does not directly affect established billing procedures, even demand billing, other than the use of indicators described below.

Special indicators are used on claims to reflect the outcome of QIO expedited determinations and reconsiderations. A set of condition codes are used to reflect these determinations. These condition codes, C1- C7, are known as the QIO approval indicator codes.

With the advent of the expedited determination process based on appeals of hospital status changes, these QIO approval indicators are used in new ways on inpatient hospital claims and skilled nursing facility. The QIO approval indicator code uses described below are valid for Original Medicare billing on the following Types of Bill: 11x, 18x, and 21x.

Providers should note that no indicators are required on claims subject to a change in status where the beneficiary does not request an expedited determination.

A. QIO Decisions Upholding a Change in Status

Providers do not report indicators on claims when they receive notification of decisions which uphold the provider's change of the beneficiary's status from inpatient to outpatient. Providers do not annotate these claims with condition code C4 to reflect the QIO denial of the appeal, since the code is defined as "Services Denied" and hospital services are not denied but will be billed on outpatient Types of Bill. In these cases, SNF services will not be billed to Original Medicare because there is no qualifying hospital stay.

B. Reporting of QIO Decisions Reversing a Change of Status

When providers are notified of QIO decisions to reverse a change of status from inpatient to outpatient, hospitals must bill the beneficiary's stay using Type of Bill 011x. Hospitals must annotate these claims with condition code C6, which is defined "Admission preauthorization" and indicates the QIO has authorized the admission but has not reviewed the services provided. Hospital shall also add Remarks stating "MCSN" to specify the circumstance of the review. These indicators will alert A/B MAC (A) that the beneficiary's inpatient status has already been subject to review and upheld by the QIO.

When billing for a SNF stay where the 3-day qualifying hospital stay was subject to a change of status review, SNFs and swing bed providers must also add condition code C6 and Remarks "MCSN" to their Type of Bill 021x or 018x admission claims. These indicators will alert the A/B MAC (A) that the beneficiary's inpatient status has already been subject to review and upheld by the QIO for the qualifying hospital stay dates reported in occurrence span code 70.

C. Billing Beneficiaries in Cases Subject to Expedited Determinations Related to Expedited Determinations Following Appeal of Status Change

If an eligible beneficiary requests an appeal timely, they would not be billed during the QIO appeals process. However, if the appeal is untimely, the hospital may bill a beneficiary before this QIO process is complete. An eligible beneficiary may file a request for review by the QIO regarding the change in status after the timely filing deadline established in regulation (that is, the beneficiary may file the request after release from the hospital) but the QIO's determination will be provided on a different timeframe and the eligible beneficiary will not be entitled to protection from billing during this time.

160 - Identifying Institutional Providers
(Rev. 11794, Issued:01-19-23, Effective: 04-01-23, Implementation:04-03-23)

Since May 23, 2007, Medicare institutional providers submit only the ten position numeric "National Provider Identifier" (NPI) as their provider identifier.

References to the six position alpha-numeric CMS Certification Number (CCN) (previously called the OSCAR number) found throughout the chapters of the Medicare Claims Processing Manual, on an ongoing basis, are supplied only for the purpose of CMS internal processing. Therefore, these references are documented as "for CMS use only".

160.1 - Reporting of Taxonomy Codes (Institutional Providers)
(Rev.11794, Issued:01-19-23, Effective: 04-01-23, Implementation:04-03-23)

Institutional providers may submit a taxonomy code on claims they submit to Medicare. Medicare does not use the taxonomy code for matching a provider's NPI to the appropriate legacy identifier. Medicare uses other claims data for this purpose. Medicare does not use the taxonomy code for any other claims processing purpose. Payers other than Medicare may have requirements for taxonomy codes. Medicare will pass any taxonomy code submitted on a Medicare claim to our trading partners on crossover claims, to allow for the possibility that those payers may use it.

If an institutional provider chooses to submit taxonomy codes, the following table supplies the crosswalk from Medicare's CMS Certification Number (CCN) to the appropriate taxonomy code based on the provider's facility type:

Provider Type	CCN Coding	Taxonomy Code
Short-term (General and Specialty) Hospitals	0001-0879 *Positions 3-6	282N00000X
Critical Access Hospitals	1300-1399 *	282NC0060X
Long-Term Care Hospitals	2000-2299 *	282E00000X
Hospital Based Renal Dialysis Facilities	2300-2499*	261QE0700X
Independent Renal Dialysis Facilities	2500-2899*	261QE0700X
Rehabilitation Hospitals	3025-3099 *	283X00000X
Children's Hospitals	3300-3399 *	282NC2000X
Hospital Based Satellite Renal Dialysis Facilities	3500-3699	Type of Bill code 72X + 261QE0700X + different zip code than any renal dialysis facility that is located on that hospital's campus
Psychiatric Hospitals	4000-4499 *	283Q00000X
Organ Procurement Organization (OPO)	P in third Position	335U00000X
Psychiatric Unit	M or S in third Position	273R00000X
Rehabilitation Unit	R or T in third Position	273Y00000X
Swing-Bed Unit	U, W, Y, or Z in third Position	Type of Bill Code X8X (swing bed) with one of the following taxonomy codes to define the type of facility in which the swing bed is located 275N00000X if unit in a short-term hospital (U), 282E00000X if unit in a long-term care hospital (W),

		283X00000X if unit in a rehab facility (Y), 282NC0060X if unit in a critical access hospital (Z)

170 - Payment Bases for Institutional Claims

(Rev. 1526, Issued: 05-30-08, Effective: 07-01-08, Implementation: 07-07-08)

There are many different payment mechanisms that apply to institutional claims. Among these are reasonable cost, prospective payment systems, all of which require at least some bundling of services, and various fee schedules.

170.1 - Services Paid on the Medicare Physician Fee Schedule (MPFS)

(Rev. 1526, Issued: 05-30-08, Effective: 07-01-08, Implementation: 07-07-08)

The following chart shows for selected Types of Bill (TOB) those revenue codes containing (some) services payable on the MPFS.

Services Payable on the MPFS
TOB by Revenue Code

Rev codes															
	12x	IHS 12x	13x	IHS 13x	22x	23x	34x	72x	74x	75x	76x	81x	82x	85x	IHS 85x
030x					X										
031x					X										
032x					X	X									
033x					X	X									
034x					X	X									
036x					X	X									
0401, 0403	X		X		X	X								X	X
0410, 0412, 0419					X	X				X					
042x	X	X	X	X	X	X	X		X	X					
043x	X	X	X	X	X	X	X		X	X					
044x	X	X	X	X	X	X	X		X	X					
046x					X	X									
471	X	X	X	X	X	X									
048x					X	X									
0550, 0559										X					
056x										X					
061x					X	X									
657												X	X		
070x					X	X									
073x					X	X									
074x					X	X									
075x					X	X									

771	X	X	X	X	X	X	X	X		X				X	X

Services Payable on the MPFS
TOB by Revenue Code (continued)

	12x	IHS 12x	13x	IHS 13x	22x	23x	34x	72x	74x	75x	76x	81x	82x	85x	HIS 85x
078x	X	X	X	X										X	X
090x					X	X				X					
091x					X	X				X					
092x					X	X									
0940, 0942, 0949					X	X				X					
096x														X	X
097x														X	X
098x														X	X

170.1.1 – Payments on the MPFS for Providers With Multiple Service Locations

(Rev. 3454, Issued: 02-04-16, Effective: 07-01-16, Implementation: 07-05-16)

Services that are paid subject to the Medicare Physician Fee Schedule (MPFS) are adjusted based on the applicable payment locality. Medicare systems determine which locality applies using ZIP codes. In cases where the provider has only one service location, the payment locality used to calculate the fee amount is determined using the ZIP code of the master address contained in the Medicare contractors' provider file.

Increasingly, hospitals operate off-site outpatient facilities. Other institutional outpatient service providers, including rehabilitation agencies and Comprehensive Outpatient Rehabilitation Facilities, may operate multiple sites. In some cases, these additional locations are in a different payment locality than the parent provider. In order for MPFS payments to be accurate, the nine-digit ZIP code of the satellite facility is used to determine the locality in these cases.

Medicare outpatient service providers report the nine-digit ZIP code of the service facility location in the 2310E loop of the 837 Institutional claim transaction. Direct Data Entry submitters also are required to report the nine-digit ZIP code of the service facility location for off-site or multiple satellite office outpatient facilities. Paper submitters report this information in Form Locator (FL) 01 on the paper claim form. Medicare systems use this service facility ZIP code to determine the applicable payment locality whenever it is present.

180 – Denial of Claims Due to Violations of Physician Self-Referral Prohibition

(Rev. 1578, Issued: 08-15-08, Effective: 01-01-09, Implementation: 01-05-09)

180.1 – Background and Policy

(Rev. 1578, Issued: 08-15-08, Effective: 01-01-09, Implementation: 01-05-09)

Under Section 1877 of the Social Security Act (the Act) (42 U.S.C. §1395nn), a physician may not refer a Medicare patient for certain designated health services (DHS) to an entity with which the physician (or an immediate family member of the physician) has a financial relationship, unless an exception applies. Section 1877 of the Act also prohibits the DHS entity from submitting claims to Medicare, the beneficiary, or any entity for DHS that are furnished as a result of a prohibited referral. The following services are DHS: clinical laboratory services; radiology and certain other imaging services (including MRIs, CT scans and ultrasound); radiation therapy services and supplies; durable medical equipment and supplies; orthotics, prosthetics, and prosthetic devices; parenteral and enteral nutrients, equipment and supplies; physical therapy, occupational therapy, speech-language pathology services; outpatient prescription drugs; home health services and supplies; and inpatient and outpatient hospital services. A "financial relationship" includes both ownership/investment interests and compensation arrangements (for example, contractual arrangements between a hospital and a physician for physician services). The statute and regulations enumerate various exceptions to the physician self-referral prohibition. Violations of the statute are punishable by denial of payment for all DHS claims, refunds of amounts collected for DHS claims, and civil money penalties for knowing violations of the prohibition. Applicable regulations are published at 42 C.F.R. Part 411, Subpart J.

180.2 – Denial Code
(Rev. 1578, Issued: 08-15-08, Effective: 01-01-09, Implementation: 01-05-09)

Prior to the publication of the new CARC #213, there was no specific code to describe claims that are denied based on a violation of the physician self-referral statute at Section 1877 of the Act. A specific code is appropriate so both the providers of DHS and the industry know that claims are being denied based on the non compliance with the physician self-referral prohibitions. This code should be used any time a claim is denied because the physician (or an immediate family member of the physician) has a financial interest in a DHS provider and fails to meet one of the exceptions available in 42 C.F.R. §§411.355-411.357.

190 – Payer Only Codes Utilized by Medicare
(Rev. 12789; Issued:08-15-24; Effective: 09-16-24; Implementation: 09-16-24)

This section contains the listing of payer codes designated by the National Uniform Billing Committee to be assigned by payers only. Providers shall not submit these codes on their claims forms. The definitions indicating Medicare's usage for these systematically assigned codes are indicated next to each code value.

Condition Codes

12-14 – Not currently used by Medicare.

15 – Clean claim is delayed in CMS Processing System.

16 – SNF Transition exception.

62 – PIP Bill.

63 – Bypass CWF edits for incarcerated beneficiaries. Indicates services rendered to a prisoner or a patient in State or local custody meets the requirement of 42 CFR 411.4(b) for payment.

64 – Other Than Clean Claim.

65 – Non-PPS Bill.

98 – Data Associated With DRG 468 Has Been Validated.

EY – Lung Reduction Study Demonstration Claims.

M0 – All-Inclusive Rate for Outpatient -Used by a Critical Access Hospital electing to be paid an all-inclusive rate for outpatient services.

M1 – Roster Billed Influenza Virus Vaccine or Pneumococcal Pneumonia Vaccine (PPV). Code indicates the influenza virus vaccine or pneumonia vaccine (PPV) is being billed via the roster billing method by providers that mass immunize.

M2 – Allows Home Health claims to process if provider reimbursement > $150,000.00. HHA Payment Significantly Exceeds Total Charges. Used when payment to an HHA is significantly in excess of covered billed charges.

M3 – SNF 3 Day stay bypass for NG/Pioneer ACO waiver.

M4 – Presence of infected wound or wound with morbid obesity

M5 – Not currently used by Medicare

M6 – PA Rural Health Model

M7 – Shared System Medicare Deductible bypass

M8 – Shared System Medicare Coinsurance bypass

M9 – Shared System Medicare Deductible/Coinsurance bypass

MA – GI Bleed. (Bill Type 072x)

MA – Managed Care Enrollee (Bill Type 012x, 013x, and 076x)

MB – Pneumonia. (Bill Type 072x)

MC – Pericarditis. (Bill Type 072x)

MD – Myelodysplastic Syndrome. (Bill Type 072x)

ME – Hereditary Hemolytic and Sickle Cell Anemia. (Bill Type 072x)

MF – Monoclonal Gammopathy. (Bill Type 072x)

MG – Grandfathered Tribal Federally Qualified Health Centers.

MH – MAC Medicare Deductible bypass

MI – MAC Medicare Coinsurance bypass

MJ – MAC Medicare Deductible/Coinsurance bypass

MK – Not currently used by Medicare.

ML – PIP claim received usual add-on only payment

MM – Medicare Merger initiated and currently in process.

MN – PIP claim received Net Reimbursement.

MO – MAC Override Appeal Timeliness.

MP – IOP/PHP claim contains initial admit week

MQ – IOP/PHP claim contains final discharge week

MR – Not currently used by Medicare.

MS – Medicare SNF 3-day inpatient hospital stay bypass

MT – Not currently used by Medicare.

MU – Medicare Part A CWF bypass

MV – 20 hours for partial IOP/PHP subsequent week not met

MW – 20 hours for partial IOP/PHP initial week net met

MX – Wrong Surgery on Patient (Inpatient)

MY – Surgery Wrong Body Part (Inpatient)

MY – Outlier Cap Bypass (CMHC)

MZ – Surgery Wrong Patient (Inpatient)

MZ – IOCE error code bypass (Outpatient)

UU – Not currently used by Medicare.

Z0 – PACE straddle claim

Z1 - Z9 – Not currently used by Medicare.

ZA – No Positive COVID-19 test result in M/R

ZB – Expanded Access approval

ZC – Clinical Trial of a different product

ZD-ZG – Not currently used by Medicare.

ZH – High Dollar Issue

ZI-ZZ – Not currently used by Medicare.

Occurrence Codes

23 – Date of Cancellation of Hospice Election period.

48 – Not currently used by Medicare.

49 – Original Notice of Election (NOE) receipt date.

AA-AZ – Not currently used by Medicare.

Occurrence Span Codes

79 – Verified non-covered stay dates for which the provider is liable.

Z0-Z9 – Not currently used by Medicare.

ZA-ZZ – Not currently used by Medicare.

Value Codes

17 – Operating Outlier Amount – The A/B MAC (A) reports the amount of operating outlier payment amount made (either cost or day (day outliers have been obsolete since 1997)) in CWF with this code. It does not include any capital outlier payment in this entry.

18 – Operating Disproportionate Share Amount – The A/B MAC (A) REPORTS THE OPERATING DISPROPORTIONATE SHARES AMOUNT APPLICIALBE. It uses the amount provided by the disproportionate share field in PRICER. It does not include any PPS capital IME adjustment entry.

19 – Outpatient Use. The Medicare shared system will display this payer only code on the claim for low volume providers to identify the amount of the low volume adjustment being included in the provider's reimbursement. This payer only code 19 is also used for IME on hospital claims. This instruction shall only apply to ESRD bill type 72x and must not impact any existing instructions for other bill types.

19 – Inpatient Use. Operating Indirect Medical Education Amount – The A/B MAC (A) reports operating indirect medical education amount applicable. It uses the amount provided by the indirect medical education field in PRICER. It does not include any PPS capital IME adjustment in this entry.

20 – Total payment sent provider for capital under PPS, including HSP, FSP, outlier, old capital, DSH adjustment, IME adjustment, and any exception amount.

62 – On Type of Bill 032x: HH Visits -Part A -The number of visits determined by Medicare to be payable from the Part A trust fund to reflect the shift of payments from the Part A to the Part B Trust Fund as mandated by §1812(a)(3) of the Social Security Act.

62 – On Type of Bills 081x 0r 082x: Number of High Routine Home Care Days - Days that fall within the first 60 days of a routine home care hospice claim.

63 – On Type of Bill 032x: HH visits – Part B -The number of visits determined by Medicare to be payable from the Part B trust fund to reflect the shift of payments from the Part A to the Part B Trust Fund as mandated by §1812(a)(3) of the Social Security Act.

63 – On Type of Bills 081x 0r 082x: Number of Low Routine Home Care Days - Days that come after the first 60 days of a routine home care hospice claim.

64 – HH Reimbursement – Part A -The dollar amounts determined to be associated with the HH visits identified in a value code 62 amount. This Part A payment reflects the shift of payments from the Part A to the Part B Trust Fund as mandated by §1812(a)(3) of the Social Security Act.

65 – HH Reimbursement – Part B -The dollar amounts determined to be associated with the HH visits identified in a value code 63 amount. This Part B payment reflects the shift of payments from the Part A to the Part B Trust Fund as mandated by §1812(a)(3) of the Social Security Act.

70 – Interest Amount – The contractor reports the amount of interest applied to this Medicare claim.

71 – Funding of ESRD Networks -The A/B MAC (A) reports the amount the Medicare payment was reduced to help fund ESRD networks.

72 – Flat Rate Surgery Charge – The standard charge for outpatient surgery where the provider has such a charging structure.

73 – Sequestration adjustment amount.

74 – Low volume hospital payment amount

75 – Prior covered days for an interrupted stay.

76 – Provider's Interim Rate – Provider's percentage of billed charges interim rate during this billing period. This applies to all outpatient hospital and skilled nursing facility (SNF) claims and home health agency (HHA) claims to which an interim rate is applicable. The contractor reports to the left of the dollar/cents delimiter. An interim rate of 50 percent is entered as follows: 50.00.

77 – Medicare New Technology Add-On Payment – Code indicates the amount of Medicare additional payment for new technology.

78 – Off-site Zip Code – When the facility zip (Loop 2310E N403 Segment) is present for the following bill types: 012X, 013X, 014X, 022X, 023X, 034X, 072X, 074X, 075X, 081X, 082X, and 085X. The ZIP code is associated with this value and is used to price MPFS HCPCS and Anesthesia Services for CAH Method II.

79 – Total payments for services applicable to the ESRD – The Medicare shared system will display this payer only code on the claim. The value represents the dollar amount for Medicare allowed payments applicable for the calculation in determining an outlier payment.

Q0 – Amount Medicare would have paid prior to the Model reduction

Q1 – Actual Model reduction amount

Q2 – Hospice claim paid from Part B Trust Fund

Q3 – Prior Authorization 25% Penalty

Q4 – PA Rural Model Exclusion - Physician Service Claim Reimbursement

Q5 – EHR

Q6 – PQRS

Q7 – Islet Isolation Add-on payment amount

Q8 – Transitional Drug Add-On Payment Adjustment

Q9 - Medicare Performance Adjustment (MPA)

QA – IOP/PHP partial week input

QB – ESRD Treatment Choices (ETC) Model: Home Dialysis Payment Adjustment (HDPA) total bonus paid.

QC – OCM+ Adjustment

QD – Device Credit

QE – ET3 Model – ET3 15% bonus payment

QF – HHA - LATE-SUB-PENALTY-AMT

QG – ESRD – Total TPNIES Amount

QH – ESRD - TPNIES capital related assets (CRA)

QI – FQHC MDPCP DEMO

QJ – ETC Model Facility PPA

QK – Maryland Waiver Kidney Acquisition Payment

QL – Not used by Medicare

QM – MIPS adjustment amount

QN – First APC pass-through device offset

QO – Second APC pass-through device offset

QP – Third APC pass-through device offset

QQ – Terminated procedure with device offset

QR – First APC pass-through drug or biological offset

QS – Second APC pass-through drug or biological offset

QT – Third APC pass-through drug or biological offset

QU –Device credit with device offset

QV – Value-based purchasing adjustment amount (Inpatient/HHA)

QV – Reserved for IOCE output

QW – IOP/PHP partial week output

QX – MCE bypass

QY-QZ – Not used by Medicare

Z0-Z8 – Not used by Medicare

Z9 – COVID-19 PHE End Date.

ZA-ZZ – Not used by Medicare

Modifiers

@0 – Not used by Medicare

@1 – System Bypass deductible

@2 – System Bypass coinsurance

@3 – System Bypass both deductible and coinsurance

@4 – MAC Bypass deductible

@5 – MAC Bypass coinsurance

@6 – MAC Bypass both deductible and coinsurance

@7-@9 – Not used by Medicare

@A-@Z – Not used by Medicare

#0-#9 – Not used by Medicare

#A-#Z – Not used by Medicare

200 - Qualified Medicare Beneficiary (QMB) Program

(Rev. 4332, Issued: 07-03-19, Effective: 10-01-19, Implementation: 10-07-19)

The Qualified Medicare Beneficiary (QMB) Program is a Medicaid program that assists low-income beneficiaries with Medicare premiums and cost-sharing. Federal law bars Medicare providers from billing an individual enrolled in QMB for Medicare Part A and Part B cost-sharing for covered items and services. See section 1902(n)(3)(B) of the Social Security Act, as modified by section 4714 of the Balanced Budget Act of 1997.

Providers and suppliers may bill State Medicaid agencies for Medicare cost-sharing amounts. However, as permitted by Federal law, States –may limit Medicare cost-sharing payments, under certain circumstances. Regardless, persons enrolled in the QMB program have no legal liability to pay Medicare providers for Medicare Part A or Part B cost-sharing for covered items and services.

Medicare providers who violate these billing prohibitions are violating their Medicare Provider Agreement and may be subject to sanctions. (See Sections 1902(n)(3)(C); 1905(p)(3); 1866(a)(1)(A); 1848(g)(3)(A) of the Social Security Act.)

Note: providers may seek reimbursement for unpaid Medicare deductible and coinsurance amounts as a Medicare bad debt. Before a provider can be reimbursed for bad debts related to dual-eligible beneficiaries, Medicare policy under CMS Pub. 15-1, Chapter 3, Section 312 of the Provider Reimbursement Manual (PRM) requires a determination and documentation of the state's liability for any cost sharing amounts. To effectuate this, Medicare requires the provider to bill the state to determine that the state is not liable for payment, even if the Medicare provider is not enrolled or the service is not covered under the state's Medicaid plan.

To aid compliance with QMB billing prohibitions, the Medicare claims processing system will generate notifications to Medicare providers (via the Remittance Advice) and beneficiaries (via the Medicare Summary Notice) that indicate the beneficiary's QMB status and lack of liability for cost-sharing. The Medicare Claims Processing System will use the Common Working File (CWF) to receive QMB status via the Eligibility Database (EDB). The QMB indicators will be transmitted to the shared systems with the applicable QMB START and END dates. The two indicators that apply to QMB individuals are Dual Status Code "01" Qualified Medicare Beneficiaries without other Medicaid (QMB-only), and Dual Status Code "02" Qualified Medicare Beneficiaries plus full Medicaid (QMB-Plus). CWF will transmit the QMB indicator if the dates of service coincide with a QMB coverage period (one of the occurrences) for the following claim types: Part B professional claims; Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) claims; and outpatient institutional and Skilled Nursing Facility (SNF) claims. CWF will transmit the QMB indicator if the discharge date falls within a QMB coverage period (one of the occurrences) for inpatient hospital claims.

QMB indicators will initiate messages on the Remittance Advice that reflect the beneficiary's QMB status and lack of liability for Medicare cost-sharing with Remittance Advice Remark Codes (RARCs) that are specific to those enrolled in QMB.

Effective July 2, 2018, for QMB claims the shared systems will use:

- Group Code “PR” along with CARC 1 and/or 2, 66, as applicable, with monetary values expressed on outbound Medicare 835 Electronic Remittance Advices (ERAs) and on standard paper remittance advices (SPRs), as applicable.

- Additionally, the shared systems shall include Alert Remittance Advice Remark Codes (RARC) on the ERA and SPR, as applicable, that designate that the beneficiary has QMB status and may not be billed for Medicare cost-sharing amounts.

    - N781 - Patient is a Medicaid/ Qualified Medicare Beneficiary. Review your records for any wrongfully collected deductible. This amount may be billed to subsequent payer.
    - N782 – Patient is a Medicaid/ Qualified Medicare Beneficiary. Review your records for any wrongfully collected co-insurance. This amount may be billed to subsequent payer.

Additionally, the Medicare Summary Notice (MSN) generated for all QMB individuals will include information regarding their QMB status and lack of liability for Medicare cost-sharing amounts for covered Parts A/B items and services.

<u>MSNs with QMB claims that are paid</u>

- If an MSN includes at least one detail line for a QMB that contains an allowed amount greater than zero, page one (the summary page), will use Message 62.0 to briefly explain the QMB billing protections (in the "Be Informed!" section). Also on page one, the patient’s total liability amount (in the “Total You May Be billed” field) will omit the deductible and coinsurance amounts for details lines that are for a QMB and include an allowed amount greater than zero.
- In the claims detail section of the MSN, if the detail line is for a QMB and includes an allowed amount greater than zero, such detail line will reflect $0 (in the “Maximum You May Be Billed” field) and include message 62.1 that informs the beneficiary of her/his QMB status and billing protections.

<u>MSNs with QMB claims that are denied</u>

- In the claim detail pages of the MSN, if a detail line is flagged as QMB and contains an allowed amount of zero, the MSN will reflect the beneficiary's total liability amount in the “Maximum You May Be Billed” field and include new MSN 11.21 message to inform the beneficiary that even though Medicare has denied the claim, Medicaid may pay for care.

Note: For claims processed by VIPS Medicare System (VMS), if a detail line is flagged as QMB and contains an allowed amount of zero, and the beneficiary has not signed an Advance Beneficiary Notice or is subject to Waiver of Liability which has not been attached, the contractor shall not print MSN message 11.21

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R13725CP	04/10/2026	New Monthly Adjustment Process for Prospective Payment System (PPS) Hospital Interim Bills Verifying Patient Status and Service Dates	10/05/2026	14416
R13272CP	06/18/2025	Updates to No Legal Obligation to Pay for or Provide Services and Examples of Application of Government Entity Exclusion (Pub. 100-02, chapter 16, sections 40 and 50.3.3 and newly created section 40.7) and Claims Submitted for Items or Services Furnished to Medicare Beneficiaries in State or Local Custody Under a Penal Authority (Pub. 100-04, chapter 1, section 10.4)	05/01/2025	13903
R13089CP	02/21/2025	Manual Updates Regarding Home Health Adjustments and Skilled Nursing Facility, Home Health and Hospice Pricer Information	05/22/2025	13955
R13026CP	12/27/2024	Billing Instructions Related to Expedited Determinations Based on Medicare Change of Status Notifications (MCSNs)	02/15/2025	13918
R13011CP	12/20/2024	Updates to No Legal Obligation to Pay for or Provide Services and Examples of Application of Government Entity Exclusion (Pub. 100-02, chapter 16, sections 40 and 50.3.3 and newly created section 40.7) and Claims Submitted for Items or Services Furnished to Medicare Beneficiaries in State or Local Custody Under a Penal Authority (Pub. 100-04, chapter 1, section 10.4)- Rescinded and Replaced by Transmittal 13272	05/01/2025	13903
R12909CP	10/24/2024	Corrections to Change Request (CR) 7270 - Changes to the Time Limits for Filing Medicare Fee For Service Claims	11/26/2024	13834
R12789CP	08/15/2024	Updates to Chapter 1 of the Medicare Claims Processing Manual (Publication (Pub.) 100-04) to Include Newly Created and Utilized Payer Only Codes	09/16/2024	13736
R12511CP	02/15/2024	Manual Updates to Chapters 1 and 17 of the Medicare Claims Processing Manual to Reflect Policies Finalized in the Calendar Year (CY) 2024 Physician Fee Schedule Final Rule	03/18/2024	13505
R12448CP	01/11/2024	Updates to Medicare Benefit Policy Manual and Medicare Claims Processing Manual for Marriage	02/12/2024	13469

Rev #	Issue Date	Subject	Impl Date	CR#
		and Family Therapists (MFTs) and Mental Health Counselors (MHCs)		
R12107CP	06/29/2023	New Fiscal Intermediary Shared System (FISS) Consistency Edit to Validate Attending Physician National Provider Identifier (NPI) - Phase 2	01/02/2024	13219
R11794CP	01/19/2023	Preventing Submission of Cross-Reference Document Control Numbers on Original Claims	04/03/2023	13008
R11633CP	10/06/2022	New Fiscal Intermediary Shared System (FISS) Consistency Edit to Validate Attending Physician National Provider Identifier (NPI)	04/03/2023	12889
R11731CP	12/09/2022	Update to the Internet Only Manual (IOM) Publication (Pub.) 100-04, Chapter 1, Section 90, to include Critical Access Hospitals (CAHs) for a Portion of a Medicare Advantage (MA) Billing Period	01/11/2023	12992
R11571CP	08/25/2022	Updates are Being Made to Chapter 1 of the Medicare Claims Processing Manual to Include Newly Created and Utilized Payer Only Codes	09/27/2022	12840
R10840CP	06/11/2021	Updates to the Internet Only Publication 100-04, Chapter 1, Section 10.1 and Chapter 20, Section 10	07/12/21	12310
R10236CP	07/31/2020	Update to the IOM Publication (Pub) 100-04, Medicare Claims Processing Manual, Chapters 1, 6, 8, 17, 20, 22, 24, and 31 Referencing the Active Universal Resource Locators (URLs) for the Washington Publishing Company (WPC) and the ASC X12 Organizations, and Updates to the HIPAA Eligibility Transaction System (HETS)	08/31/2020	11857
	12/06/2019	Update to Medicare Claims Processing Manual, Chapters 1, 23 and 35	03/09/2020	10882
R4415CP	10/11/2019	Medicare Administrative Contractor (MAC) Guidance Related to Use of Adjustment Codes on Adjustment Claims	01/06/2020	11113
R4388CP	09/06/2019	Manual Updates to Chapters 1, 22, 24, 26, and 31 in Publication (Pub.) 100-04	10/01/2019	11331
R4381CP	08/30/2019	Updates to Chapter 1 Payer Only Codes in the Medicare Claims Processing Manual	10/01/2019	11414
R4337CP	07/18/2019	Implementation of the Medicare Performance Adjustment (MPA) for the Maryland Total Cost of Care (MD TCOC) Model	07/01/2019	10971

Rev #	Issue Date	Subject	Impl Date	CR#
R4332CP	07/03/2019	Medicare Summary Notice (MSN) Changes to Assist Beneficiaries Enrolled in the Qualified Medicare Beneficiary (QMB) Program	10/07/2019	11230
R4308CP	05/16/2019	Implementation of the Medicare Performance Adjustment (MPA) for the Maryland Total Cost of Care (MD TCOC) Model- Rescinded and Replaced by Transmittal 4337	07/01/2019	10971
R4290CP	05/03/2019	Medicare Summary Notice (MSN) Changes to Assist Beneficiaries Enrolled in the Qualified Medicare Beneficiary (QMB) Program - Rescinded and Replaced by Transmittal 4332	10/07/2019	11230
R4271CP	03/29/2019	Update to the Internet-Only-Manual (IOM) Publication (Pub.) 100-04, Chapters 1 and 3	04/29/2019	11188
R4257CP	03/14/2019	Implementation of the Medicare Performance Adjustment (MPA) for the Maryland Total Cost of Care (MD TCOC) Model- Rescinded and Replaced by Transmittal 4308	07/01/2019	10971
R4230CP	02/01/2019	Implementation of the Medicare Performance Adjustment (MPA) for the Maryland Total Cost of Care (MD TCOC) Model- Rescinded and Replaced by Transmittal 4257	07/01/2019	10971
R4201CP	01/18/2019	Update to Pub. 100-04 Chapter 1 to Provide Language-Only Changes for the New Medicare Card Project	02/19/2019	10916
R4163CP	11/02/2018	Internet Only Manual Updates to Pub. 100-01, 100-02 and 100-04 to Correct Errors and Omissions (SNF) (2018 Q4)	12/04/2018	11004
R4035CP	04/27/2018	Enhancements to Processing of Hospice Routine Home Care Payments	10/01/2018	10573
R4047CP	05/11/2018	Updates to Publication 100-04, Chapters 1 and 27 to Replace Remittance Advice Remark Code (RARC) MA61 with N382	08/13/2018	10619
R4001CP	03/16/2018	Internet Only Manual Updates to Pub. 100-01, 100-02 and 100-04 to Correct Errors and Omissions (SNF) (2018)	06/19/2018	10512
R3993CP	03/06/2018	Reinstating the Qualified Medicare Beneficiary Indicator in the Medicare Fee-For-Service Claims Processing System from CR 9911	07/02/2018	10433
R3965CP	02/02/2018	Reinstating the Qualified Medicare Beneficiary Indicator in the Medicare Fee-For-Service Claims Processing System from CR 9911 Rescinded and	07/02/2018	10433

Rev #	Issue Date	Subject	Impl Date	CR#
		Replaced by Transmittal 3993		
R3933CP	12/07/2017	Revisions to the Home Health Pricer to Support Value-Based Purchasing and Payment Standardization	01/02/2018	10167
R3920CP	11/05/2017	Qualified Medicare Beneficiary Indicator in the Medicare Fee-For-Service Claims Processing System	07/03/2017	9911
R3829CP	08/04/2017	Revisions to the Home Health Pricer to Support Value-Based Purchasing and Payment Standardization- Rescinded and Replaced by Transmittal 3933	01/02/2018	10167
R3802CP	06/28/2017	Qualified Medicare Beneficiary Indicator in the Medicare Fee-For-Service Claims Processing System- Rescinded and Replaced by Transmittal 3920	07/03/2017	9911
R3774CP	05/12/2017	Changes to the Payment Policies for Reciprocal Billing Arrangements and Fee-For-Time Compensation Arrangements (formerly referred to as Locum Tenens Arrangements)	06/13/2017	10090
R3764CP	04/28/2017	Qualified Medicare Beneficiary Indicator in the Medicare Fee-For-Service Claims Processing System	07/03/2017	9911
R3715CP	02/02/2017	Qualified Medicare Beneficiary Indicator in the Medicare Fee-For-Service Claims Processing System	07/03/2017	9911
R3537CP	06/08/2016	Corrections to Chapter 1 of the Medicare Claims Processing Manual	08/08/2016	9623
R3519CP	05/06/2016	Corrections to Chapter 1 of the Medicare Claims Processing Manual - Rescinded and replaced by Transmittal 3537	08/08/2016	9623
R3510CP	04/29/2016	Updates to Pub. 100-04, Chapters 1 and 16 to Correct Remittance Advice Messages	10/03/2016	9578
R3503CP	04/28/2016	Billing of Vaccine Services on Hospice Claims – Rescinded and replaced by Transmittal 3540	10/03/2016	9052
R3475CP	03/04/2016	Updates to Pub. 100-04, Chapters 4 and 5 to Correct Remittance Advice Messages	06/06/2016	9424
R3454CP	02/04/2016	Correction to Applying Therapy Caps to Maryland Hospitals and Billing Requirement for Rehabilitation Agencies and Comprehensive Outpatient Rehabilitation Facilities (CORFs)	07/05/2016	9489
R3415CP	11/23/2015	Payment for Grandfathered Tribal Federally Qualified Health Centers (FQHCs) that were Provider-Based Clinics on or Before April 7, 2000	01/04/2016	9267

Rev #	Issue Date	Subject	Impl Date	CR#
R3398CP	11/06/2015	Processing Hospice Denials When Face-to-Face Encounter is Not Received Timely	04/04/2016	9385
R3389CP	10/30/2015	Outpatient Mental Health Treatment Limitation Split Claims Fix	04/04/2016	9306
R3313CP	08/06/2015	Payment for Grandfathered Tribal Federally Qualified Health Centers (FQHCs) that were Provider-Based Clinics on or Before April 7, 2000 - Rescinded and replaced by Transmittal 3415	01/04/2016	9267
R3287CP	06/30/2015	Revisions to Medicare Claims Processing Manual for Foreign, Emergency and Shipboard Claims	04/21/2015	8940
R3262CP	05/15/2015	Manual Update to Pub. 100-04, Chapter 1, to include Claims Submitted by Multiple DMEPOS Suppliers	07/06/2015	9079
R3255CP	05/08/2015	Correction to the Multi-Carrier System (MCS) Editing on the Service Location National Provider Identifier (NPI) Reported for Anti-Markup and Reference Laboratory Claims	10/05/2015	9150
R3219CP	03/16/2015	Automation of the Request for Reopening Claims Process	10/06/2014	8581
R3199CP	02/20/2015	Revisions to Medicare Claims Processing Manual for Foreign, Emergency and Shipboard Claims – Rescinded and replaced by Transmittal 3287	04/21/2015	8940
R3203CP	02/20/2015	Automation of the Request for Reopening Claims Process – Rescinded and replaced by Transmittal 3219	10/06/2014	8581
R3164CP	01/14/2015	Medicare Shared Systems Modifications Necessary to Capture Various HIPAA Compliant Fields	04/06/2015	8384
R3154CP	12/19/2014	Automation of the Request for Reopening Claims Process – Rescinded and replaced by Transmittal 3203	10/06/2014	8581
R3107CP	11/06/2014	Medicare Shared Systems Modifications Necessary to Capture Various HIPAA Compliant Fields – Rescinded and replaced by Transmittal 3164	04/06/2015	8384
R3103CP	11/03/2014	Reporting the Service Location National Provider Identifier (NPI) on Anti-Markup and Reference Laboratory Claims	04/06/2015	8806
R3098CP	10/21/2014	Reporting the Service Location National Provider Identifier (NPI) on Anti-Markup and Reference Laboratory Claims – Rescinded and replaced by Transmittal 3103	04/05/2015	8806
R3086CP	10/03/2014	Update to Pub. 100-04, Chapter 1 to Provide Language-Only Changes for Updating ICD-10 and ASC X12	11/04/2013	8687

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R3060CP	09/03/2014	Automation of the Request for Reopening Claims Process – Rescinded and replaced by Transmittal 3154	10/06/2014	8581
R3051CP	08/25/2014	Adjustment to Fiscal Intermediary Shared System (FISS) Consistency Edit to Implement National Uniform Billing Committee (NUBC) Revision to Occurrence Span Code (OSC) Definition for Code 72	10/06/2014	8655
R3047CP	08/22/2014	Reporting the Service Location National Provider Identifier (NPI) on Anti-Markup and Reference Laboratory Claims – Rescinded and replaced by Transmittal 3098	01/05/2014	8806
R3022CP	08/08/2014	Automation of the Request for Reopening Claims Process – Rescinded and replaced by Transmittal 3060	10/06/2014	8581
R3001CP	08/01/2014	Adjustment to Systematic Validation of Payment Group Codes for Prospective Payment Systems (PPS) Based on Patient Assessments	01/05/2015	8654
R2984CP	07/11/2014	Beneficiary Signature Requirements for Ambulance Services	08/12/2014	8760
R2950CP	05/08/2014	Adjustment to Fiscal Intermediary Shared System (FISS) Consistency Edit to Implement National Uniform Billing Committee (NUBC) Revision to Occurrence Span Code (OSC) Definition for Code 72 – Rescinded and replaced by Transmittal 3051	10/06/2014	8655
R2944CP	05/02/2014	Automation of the Request for Reopening Claims Process – Rescinded and replaced by Transmittal 3022	10/06/2014	8581
R2921CP	04/04/2014	Internet Only Manual Updates to Pub. 100-01, 100-02 and 100-04 to Correct Errors and Omissions	05/05/2014	8669
R2896CP	03/07/2014	Indirect Payment Procedure (IPP) - Payment to Entities that Provide Coverage Complementary to Medicare Part B	06/06/2014	8638
R2876CP	02/07/2014	Update to Pub 100-04, Claims Processing Manual, Chapter One	03/07/2014	8442
R2815CP	11/15/2013	Updates to the Medicare Claims Processing Internet-Only Manual (IOM)	03/18/2014	8490
R2799CP	10/25/2013	Annual Medicare Physician Fee Schedule (MPFS) Files Delivery and Implementation	01/06/2014	8462
R2783CP	09/10/2013	Corrections to the Medicare Claims Processing Manual	09/17/2013	8343

Rev #	Issue Date	Subject	Impl Date	CR#
R2767CP	08/16/2013	Handling of Incomplete or Invalid Claims once the Phase 2 Ordering and Referring Edits are Implemented	01/06/2013	8356
R2759CP	08/09/2013	Update to the Claims Processing Internet-Only Manual (IOM) to Add the National Uniform Billing Committee (NUBC) Payer Only Codes	11/12/2013	8413
R2725CP	06/14/2013	Corrections to the Medicare Claims Processing Manual – Rescinded and replaced by Transmittal 2783	09/17/2013	8343
R2722CP	06/11/2013	Changes to Contractor Designation in Processing Foreign, Emergency and Shipboard Claims	01/29/2012	8103
R2694CP	05/03/2013	Discontinuation of Home Health Type of Bill 33X	10/07/2013	8244
R2678CP	03/26/2013	Clarification of Detection of Duplicate Claims Section of the CMS Internet Only Manual	04/29/2013	8121
R2674CP	03/14/2013	Changes to Contractor Designation in Processing Foreign, Emergency and Shipboard Claims – Rescinded and replaced by Transmittal 2722	01/29/2012	8103
R2648CP	02/01/2013	Adjustment to Fiscal Intermediary Shared System (FISS) Consistency Edit to Validate Attending Physician NPI	07/01/2013	8171
R2625CP	12/28/2012	Changes to Contractor Designation in Processing Foreign, Emergency and Shipboard Claims – Rescinded and replaced by Transmittal 2674	01/29/2012	8103
R2614CP	12/14/2012	Updated Billing Requirements for Outpatient Therapy Services -- Middle Class Tax Relief and Jobs Creation Act (MCTRJCA) of 2012	11/27/2012	8097
R2578CP	11/01/2012	Enforcing Interim Billing for Partial Hospitalization Services	04/01/2013	8048
R2571CP	10/26/2012	Updated Billing Requirements for Outpatient Therapy Services – Middle Class Tax Relief and Jobs Creation Act (MCTRJCA) of 2012 – Rescinded and replaced by Transmittal 2614	11/27/2012	8097
R2560CP	09/28/2012	New Fiscal Intermediary Shared System (FISS) Consistency Edit to Validate Attending Physician NPI	01/07/2013	7902
R2519CP	08/17/2012	New Fiscal Intermediary Shared System (FISS) Consistency Edit to Validate Attending Physician NPI – Rescinded and replaced by Transmittal 2560	01/07/2013	7902
R2515CP	08/08/2012	Handling Form CMS-1500 Hard Copy Claims Where and ICD-9-C< “E” Code or Where and ICD-10 V00-Y99 Code is Reported as the First Diagnosis on the Claim	01/07/2013	7700

Rev #	Issue Date	Subject	Impl Date	CR#
R2500CP	07/27/2012	Clarification of the Use of the Electronic Claim Format to Indicate Where a Service Was Performed	08/27/2012	7871
R2495CP	07/18/2012	Systematic Validation of Payment Group Codes for Prospective Payment Systems (PPS) Based on Patient Assessments	10/01/2012	7760
R2487CP	06/08/2012	Internet Only Manual (IOM) Update for Laboratory Services and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Claims Processed under the End Stage Renal Disease Prospective Payment System (ESRD PPS)	06/19/2012	7749
R2477CP	05/25/2012	Modifying the Timely Filing Exceptions on Retroactive Medicare Entitlement and Retroactive Medicare Entitlement Involving State Medicaid Agencies	08/27/2012	7834
R2475CP	05/18/2012	Internet Only Manual (IOM) Update for Laboratory Services and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Claims Processed under the End Stage Renal Disease Prospective Payment System (ESRD PPS)	06/19/2012	7749
R2474CP	05/18/2012	Handling Misdirected Claims for Part B Items and Services	07/20/2012	7629
R2463CP	05/04/2012	New Fiscal Intermediary Shared System (FISS) Edit to Review Medicare Outpatient Prospective Payment System (OPPS) Payments Exceeding Charges	10/01/2012	7771
R2458CP	04/27/2012	Systematic Validation of Payment Group Codes for Prospective Payment Systems (PPS) Based on Patient Assessments – Rescinded and replaced by Transmittal 2495	10/01/2012	7760
R2386CP	01/13/2012	January 2012 Update of the Hospital Outpatient Prospective Payment System (OPPS)	01/03/2012	7672
R2376CP	12/29/2011	January 2012 Update of the Hospital Outpatient Prospective Payment System (OPPS) – Rescinded and replaced by Transmittal 2386	01/03/2012	7672
R2342CP	11/04/2011	Annual Medicare Physician Fee Schedule Files Delivery and Implementation Manualization	01/03/2012	7607
R2296CP	09/02/2011	October 2011 Update of the Hospital Outpatient Prospective Payment System (OPPS)	10/03/2011	7545
R2291CP	08/26/2011	Fiscal Year (FY) 2012 Inpatient Prospective Payment System (IPPS), Long Term Care Hospital (LTCH) PPS, and Critical Access Hospital (CAH) Changes	10/03/2011	7508
R2228CP	05/20/2011	Manual Update for Quarterly Reporting Requirements for Do Not Forward Reports	06/06/2011	7295

Rev #	Issue Date	Subject	Impl Date	CR#
R2221CP	05/20/2011	Postcard Mailing for the Annual Participation Open Enrollment Period – Rescinded and replaced by Transmittal 2228	10/31/2011	7412
R2208CP	05/06/2011	Manual Update for Quarterly Reporting Requirements for Do Not Forward Reports	06/06/2011	7295
R2203CP	04/29/2011	Home Health Requests for Anticipated Payment and Timely Claims Filing	10/03/2011	7396
R2162CP	02/22/2011	Updates to the Internet Only Manual Pub. 100-04, Chapter 1 - General Billing Requirements, Chapter 15 - Ambulance, and Chapter 26 - Completing and Processing Form CMS-1500 Data Set	03/21/2011	7018
R2140CP	01/21/2011	Changes to the Time Limits for Filing Medicare Fee-For-Service Claims	02/22/2011	7270
R2124CP	12/23/2010	Updates to the Internet Only Manual Pub. 100-04, Chapter 1 - General Billing Requirements, Chapter 15 - Ambulance, and Chapter 26 - Completing and Processing Form CMS-1500 Data Set - Rescinded and replaced by Transmittal 2162	01/25/2011	7018
R2112CP	12/03/2010	Common Working File (CWF) Unsolicited Response Adjustments for Certain Claims Denied Due to an Open Medicare Secondary Payer (MSP) Group Health Plan (GHP) Record Where the GHP Record was Subsequently Deleted or Terminated	01/03/2011	6625
R2092CP	11/12/2010	Update to the Frequency Billing Requirements	04/04/2011	7163
R2061CP	10/01/2010	October 2010 Update of the Hospital Outpatient Prospective Payment System (OPPS)	10/04/2010	7117
R2050CP	09/17/2010	October 2010 Update of the Hospital Outpatient Prospective Payment System (OPPS) – Rescinded and replaced by Transmittal 2061	10/04/2010	7117
R2041CP	08/31/2010	Revisions to Claims Processing Instructions for Services Rendered in Place of Service Home	01/03/2011	6947
R2031CP	08/20/2010	Beneficiary-Submitted Claims	11/29/2010	6874
R2015CP	07/30/2010	Revisions to Claims Processing Instructions for Services Rendered in Place of Service Home - Rescinded and replaced by Transmittal 2041	01/03/2011	6947
R2014CP	07/30/2010	Common Working File (CWF) Unsolicited Response Adjustments for Certain Claims Denied Due to an Open Medicare Secondary Payer (MSP) Group Health Plan (GHP) Record Where the GHP Record was Subsequently Deleted or Terminated – Rescinded and replaced by Transmittal 2112	01/03/2011	6625
R1987CP	06/11/2010	Correction to the Claims Processing Internet Only Manual (IOM) to Reinstate Previous Instructions	08/12/2010	6923

Rev #	Issue Date	Subject	Impl Date	CR#
		Regarding Payment Jurisdiction for Reassigned Services		
R1946CP	04/15/2010	Billing and Processing Claims with Unlimited Occurrence Span Codes (OSCs)	07/06/2010	6777
R1944CP	04/09/2010	Claims Submitted for Items or Services Furnished to Medicare Beneficiaries in State or Local Custody Under a Penal Authority and Examples of Application of Government Entity Exclusion. This CR rescinds and fully replaces CR 6544.	07/09/2010	6880
R1934CP	03/19/2010	Billing and Processing Claims with Unlimited Occurrence Span Codes (OSCs) – Rescinded and replaced by Transmittal 1946	07/06/2010	6777
R1931CP	03/12/2010	Revision of the Internet Only Manual (IOM) to Remove References to "Purchased Diagnostic Test" and Replace With Language Consistent With the Anti-Markup Rule	06/14/2010	6627
R1928CP	03/05/2010	Correction to Processing of Non-Covered Revenue Codes	07/06/2010	6774
R1921CP	02/19/2010	Billing for Services Related to Voluntary Uses of Advanced Beneficiary Notices of Noncoverage (ABNs)	04/05/2010	6563
R1903CP	01/29/2010	Instructions for Processing Claims Containing Anti-Markup Services but with Partial Information Completed in Item 20 of the Form CMS-1500	04/05/2010	6670
R1900CP	01/29/2010	Correction to Processing of Non-Covered Revenue Codes - Rescinded and replaced by Transmittal 1928	07/06/2010	6774
R1895CP	01/15/2010	Processing of Non-Covered International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) Procedure Codes on Inpatient Hospital Claims	04/05/2010	6547
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R1892CP	01/15/2010	Payment to Physician or Other Supplier for Diagnostic Tests Subject to the Anti-Markup Payment Limitation	03/15/2010	6733
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R1840CP	10/29/2009	Billing for Services Related to Voluntary Uses of Advanced Beneficiary Notices of Noncoverage (ABNs) – Rescinded and replaced by Transmittal 1894	04/05/2010	6563
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R1747CP	05/22/2009	Beneficiary-Submitted Claims	06/23/2009	6434
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R1733CP	05/08/2009	Manual Clarification for Skilled Nursing Facility (SNF) and Therapy Billing	04/27/2009	6407
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R492CP	03/04/2005	Adding an Indicator to the National Claims History (NCH) to Indicate that DMERCs, Carriers, and FIs have Reviewed a Potentially Duplicate Claim	07/05/2005	2965
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R341CP	10/29/2004	Implementation of the Medicare Physician Fee Schedule (MPFS) National Abstract File for Purchased Diagnostic Tests and Interpretations	04/04/2005	3481
R332CP	10/22/2004	New Policy and Refinements on Billing Noncovered Charges to Fiscal Intermediaries (FIs)	04/04/2005	3416
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