CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 4203	**Date: January 18, 2019**
	Change Request 11079

SUBJECT: Update to Pub. 100-04 Chapter 32 to Provide Language-Only Changes for the New Medicare Card Project

I. SUMMARY OF CHANGES: This CR contains language-only changes for updating the New Medicare Card Project-related language in Pub 100-04, Chapter 32. There are no new coverage policies, payment policies, or codes introduced in this transmittal. Specific policy changes and related business requirements have been announced previously in various communications.

EFFECTIVE DATE: February 19, 2019
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: February 19, 2019

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	32/12/12.7/Common Working File (CWF) Inquiry
R	32/80/80.7/CWF General Information
R	32/360/360.3.4/Full Denial - Hospital-Filed or Beneficiary-Filed Emergency Claim
R	32/360/360.3.5/Partial Denial - Hospital-Filed or Beneficiary-Filed Emergency Claim
R	32/360/360.3.6/Denial - Military Personnel/Eligible Dependents
R	32/360/360.3.7/Full Denial - Shipboard Claim - Beneficiary Filed
R	32/360/360.3.8/Full Denial - Foreign Claim - Beneficiary Filed

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question

and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 4203	Date: January 18, 2019	Change Request: 11079

SUBJECT: Update to Pub. 100-04 Chapter 32 to Provide Language-Only Changes for the New Medicare Card Project

EFFECTIVE DATE: February 19, 2019
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I. GENERAL INFORMATION

A. Background: The Centers for Medicare & Medicaid Services (CMS) is implementing changes to remove the Social Security Number (SSN) from the Medicare card. A new number, called the Medicare Beneficiary Identifier (MBI), will be assigned to all Medicare beneficiaries. This CR contains language-only changes for updating the New Medicare Card Project language related to the MBI in Pub 100-04, Chapter 32.

B. Policy: The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires removal of the Social Security Number (SSN)-based Health Insurance Claim Number (HICN) from Medicare cards within four years of enactment. There are no new coverage policies, payment policies, or codes introduced in this transmittal. Specific policy changes and related business requirements have been announced previously in various communications.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11079.1	MACs shall be aware of the updated language for the New Medicare Card Project in Pub. 100-04, Chapter 32.	X	X	X	X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Tracey Mackey, 410-786-5736 or Tracey.Mackey@cms.hhs.gov , Kimberly Davis, 410-786-4721 or kimberly.davis@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

Medicare Claims Processing Manual
Chapter 32 – Billing Requirements for Special Services

12.7 - Common Working File (CWF) Inquiry
(Rev. 4203, 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 Common Working File (CWF) maintains the number of counseling sessions rendered to a beneficiary. By entering the beneficiary's *Medicare beneficiary identifier*, providers have the capability to view the number of sessions a beneficiary has received for this service via inquiry through CWF.

80.7 - CWF General Information
(Rev. 4203, 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.

Though G0245 and G0246 have no technical or professional components, for these codes, CWF will post institutional claims with type of bill 13X as technical, and professional claims as professional. For bill type 85X with revenue code 940, CWF will post as technical. For 85X bill type with revenue code 98X, (Method II), CWF will post as technical and professional. This will allow both the facility and professional service payments to be approved by CWF for payment when the code and date of service match. Therefore, should a claim be received with the same code and same date of service for the same beneficiary, the second claim submitted will not be rejected as a duplicate.

Due to the billing and payment methodology of Rural Health Clinics - bill type 71X and Federally Qualified Health Centers - bill type 73X, CWF will post these claims as usual, which will correctly allow claims from these entities that are billed on institutional claims to reject as duplicates when the HCPCS code, date of service, and *Medicare beneficiary identifier* are an exact match with a claim billed on a professional claim.

Medicare contractors must react to these duplicate claims as they currently do for any other duplicates.

360.3.4 - Full Denial - Hospital-Filed or Beneficiary-Filed Emergency Claim
(Rev. 4203, 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.

Contractors shall include beneficiary appeal rights language and include in the mailing a redetermination request form where applicable.

MODEL DENIAL NOTICE A
(MAC'S NAME AND ADDRESS)

Date: ______________

Beneficiary: ____________________

Claim Number ________________

DETERMINATION ON EMERGENCY HOSPITAL SERVICES

We are sorry, but payment cannot be made for your stay from _______ through _______ at (hospital). This is because the (hospital) does not participate in the Medicare program and it has been determined that your treatment there does not qualify as emergency care.

Under the law, payment for services received in a nonparticipating hospital can be made only if you go, or are brought to, the hospital to receive emergency care. Emergency care under Medicare is defined as:

a. Care which is necessary to prevent the death or serious impairment to the health of the individual; and

b. Which, because of threat to the life or health of the individual, requires the use of the nearest hospital (in miles or travel time) that has a bed available and is equipped to handle the emergency.

The medical facts of your hospital admission and stay have been carefully reviewed. Based upon this review, we have found that, although it was necessary for you to be hospitalized, a medical emergency did not exist. There would have been time for you to have been admitted to a hospital participating in Medicare.

If you have questions about this notice, you may call 1-800-MEDICARE (1-800-633-4227) for additional information. If you believe the determination is not correct, you may request a redetermination. You must file your request within 120 days from the date you receive this notice. A request for a redetermination must be filed either on Form CMS-20027 or on a written request that includes all of the elements listed below.

- Beneficiary name
- Medicare *beneficiary identifier*
- Specific service and/or item(s) for which a redetermination is being requested
- Specific date(s) of service
- Signature of the beneficiary or the beneficiary's authorized or appointed representative.

You may send the request to our address above. Please keep a copy of any written correspondence for your files.

Sincerely,

360.3.5 - Partial Denial - Hospital-Filed or Beneficiary-Filed Emergency Claim

(Rev. 4203, 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.

MODEL DENIAL NOTICE A
(MAC'S NAME AND ADDRESS)

Date: _______________

Beneficiary: ______________________

Claim Number _________________

DETERMINATION ON EMERGENCY HOSPITAL SERVICES

This refers to your request for payment under Medicare for the services received while a patient at (hospital), from _______ through _______.

Payment can be made under the hospital insurance part of Medicare only for the costs of your hospitalization from _______ to _______.

The (hospital) does not participate in the Medicare program. Under the law, payment for services received in a nonparticipating hospital can be made only if you go, or are brought to, the hospital to receive emergency care. Emergency care under Medicare is defined as:

a. Care which is necessary to prevent the death or serious impairment to the health of the individual; and

b. Which, because of threat to the life or health of the individual, requires the use of the nearest hospital (in miles or travel time) which has a bed available and is equipped to handle the emergency.

Payment for emergency services stops when the emergency ends and it is permissible, from a medical standpoint, either to transfer the patient to a participating hospital or to discharge him.

The medical facts of your hospital admission and stay have been carefully reviewed. Based upon this review, we have found that an emergency condition existed when you were admitted. However, the medical information indicates that this emergency condition ended on _________. At that time, your condition had improved to the extent that you could have been transferred to a hospital participating in the Medicare program.

If you have questions about this notice, you may call 1-800-MEDICARE (1-800-633-4227) for additional information. If you believe the determination is not correct, you may request a redetermination. You must file your request within 120 days of the date you receive this notice. A request for a redetermination must be filed either on Form CMS-20027 or on a written request that includes all of the elements listed below.

- Beneficiary name
- Medicare *beneficiary identifier*
- Specific service and/or item(s) for which a redetermination is being requested
- Specific date(s) of service

- Signature of the beneficiary or the beneficiary's authorized or appointed representative.

You may send the request to our address listed above. Please keep a copy of any written correspondence for your files.

Sincerely,

360.3.6 - Denial - Military Personnel/Eligible Dependents

(Rev. 4203, Issued: 01-18-19, Effective: 02-19-19, Implementation: 02-19-19)

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MODEL DENIAL NOTICE A

(MAC'S NAME AND ADDRESS)

Date: ______________

Beneficiary: ____________________

Claim Number ________________

DETERMINATION ON EMERGENCY HOSPITAL SERVICES

We are sorry, but payment cannot be made for your stay from________ through________ at (hospital).

Under the law, medical services that have been furnished by a federal hospital to retired members of the armed services, or their eligible dependents, are not covered under the Medicare program.

If you have questions about this notice, you may call 1-800-MEDICARE (1-800-633-4227) for additional information. If you believe the determination is not correct, you may request a redetermination. You must file your request within 120 days from the date you receive this notice. A request for a redetermination must be filed either on Form CMS-20027 or on a written request that includes all of the elements listed below.

- Beneficiary name
- Medicare *beneficiary identifier*
- Specific service and/or item(s) for which a redetermination is being requested
- Specific date(s) of service
- Signature of the beneficiary or the beneficiary's authorized or appointed representative.

You may send the request to our address listed above. Please keep a copy of any written correspondence for your files.

Sincerely,

360.3.7 - Full Denial - Shipboard Claim - Beneficiary Filed

(Rev. 4203, 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.

MODEL DENIAL NOTICE
(MAC'S NAME AND ADDRESS)

Date: ____________________

Beneficiary: _________________________

Claim Number: __________________

DETERMINATION ON SHIPBOARD SERVICES

We are sorry, but medical services provided on the (vessel/ship's name) cruise ship are not covered. The Medicare program can make payment for medically necessary shipboard services only if all of the following requirements are met:

1. The services are furnished while the ship is within the territorial waters of the United States (in a U.S. port, or within 6 hours of departure or arrival at a U.S. port).
2. The services are furnished to an individual who is entitled to Part B benefits;
3. The services are furnished in connection with covered inpatient hospital services;
4. The services furnished on the ship are for the same condition that required inpatient admission;
5. The physician is legally authorized to practice in the country where he or she furnishes the services.

If you have a supplemental insurance policy, you should check with the company carrying that policy to see if they cover these services and what procedures you should follow in submitting your claim.

If you have questions about this notice, you may call 1-800-MEDICARE (1-800-633-4227) for additional information. If you believe the determination is not correct, you may request a redetermination. You must file your request within 120 days from the date you receive this notice. A request for a redetermination must be filed either on Form CMS-20027 or on a written request that includes all of the elements listed below.

- Beneficiary name
- Medicare *beneficiary identifier*
- Specific service and/or item(s) for which a redetermination is being requested
- Specific date(s) of service
- Signature of the beneficiary or the beneficiary's authorized or appointed representative.

You may send the request to our address listed above. Please keep a copy of any written correspondence for your files.
Sincerely,

360.3.8 - Full Denial - Foreign Claim - Beneficiary Filed

(Rev. 4203, Issued: 01-18-19, Effective: 02-19-19, Implementation: 02-19-19)

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MODEL DENIAL
NOTICE (MAC'S NAME AND ADDRESS)

Date:____________________

Beneficiary:______________________ Claim Number: ___________

DETERMINATION ON FOREIGN HOSPITAL SERVICES

We are sorry, but payment cannot be made for your stay from____through
____at (hospital) in (country).

Medicare law prohibits payment for items and services furnished outside the United States except in certain limited circumstances. The term "outside the U.S." means anywhere other than the 50 states of the U.S., the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

There are three situations when Medicare may pay for certain types of health care services rendered in a foreign hospital (a hospital outside the U.S.):

1. You're in the U.S. when you have a medical emergency and the foreign hospital is closer than the nearest U.S. hospital that can treat your illness or injury.
2. You're traveling through Canada without unreasonable delay by the most direct route between Alaska and another state when a medical emergency occurs, and the Canadian hospital is closer than the nearest U.S. hospital that can treat your illness or injury. Medicare determines what qualifies as "without unreasonable delay" on a case-by-case basis.
3. You live in the U.S. and the foreign hospital is closer to your home than the nearest U.S. hospital that can treat your medical condition, regardless of whether it's an emergency.

In these situations, Medicare will pay only for the Medicare-covered services you get in a foreign hospital.

If you have a supplemental insurance policy, you should check with the company carrying that policy to see if they cover these services and what procedures you should follow in submitting your claim.

If you have questions about this notice, you may call 1-800-MEDICARE (1-800-633-4227) for additional information. If you believe the determination is not correct, you may request a redetermination. You must file your request within 120 days from the date you receive this notice. A request for a redetermination must be filed either on Form CMS-20027 or on a written request that includes all of the elements listed below.

- Beneficiary name
- Medicare *beneficiary identifier*
- Specific service and/or item(s) for which a redetermination is being requested
- Specific date(s) of service
- Signature of the beneficiary or the beneficiary's authorized or appointed representative.

You may send the request to our address listed above. Please keep a copy of any written correspondence for your files.

Sincerely,