CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1169	**Date: FEBRUARY 2, 2007**
	Change Request 5248

Subject: Revision of Editing to Ensure Demand Bills Remain Identifiable in Claims History After Processing

I. SUMMARY OF CHANGES: This transmittal revises Medicare systems to ensure that demands are only required to report at least one non-covered line item at the point of receipt, not at later points in processing.

New / Revised Material
Effective Date: July 1, 2007
Implementation Date: July 2, 2007

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	1/60.3.2/General Demand Billing Instructions, Inpatient and Outpatient (Other than HH PPS and Part A SNF)

III. FUNDING:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2007 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

Unless otherwise specified, the effective date is the date of service.

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1169	Date: February 2, 2007	Change Request: 5248

SUBJECT: Revision of Editing to Ensure Demand Bills Remain Identifiable in Claims History After Processing

Effective Date: July 1, 2007

Implementation Date: July 2, 2007

I. GENERAL INFORMATION

A. Background: In October 2003, CMS issued Change Request 2634 which provided comprehensive instructions regarding the submission and processing of non-covered charges. Requirement 2634.3.3.2 of that Change Request required Medicare systems to return claims submitted by institutional providers if the claims were identified as demand bills and reported all covered charges. Since non-covered charges on demand bills indicate the services in dispute, a claim reporting condition code 20 (the demand billing indicator) and all covered charges represents contradictory data and cannot be processed. It is correct for the Fiscal Intermediary Shared System (FISS) edit enforcing this requirement to set on claims when they are initially submitted by the provider.

CMS has learned that the FISS edit enforcing this requirement continues to apply to claims after they are received and throughout processing. For example, a demand bill may be medically reviewed and the reviewer finds that all the services in dispute are covered. In this case, the reviewer changes the provider-submitted non-covered charges to be covered charges and allows the claim to continue processing. Currently, the FISS edit is also setting in this situation, requiring the reviewer to remove the condition code 20 from the claim. This creates an unintended and unnecessary manual process. It also has an adverse effect on CMS National Claims History data, artificially reducing the number of claims that can be identified as demand bills.

B. Policy: Claims submitted as demand bills are required to be submitted by the provider with at least one line item reporting non-covered charges. This requirement will be enforced only upon the initial receipt of the claim from the provider. It will not continue to be enforced as the claim is processed through Medicare systems.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes mandatory requirements

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5248.1	Medicare systems shall ensure the claims reporting condition code 20 also contain at least one line item with non-covered charges when received from the provider.							X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	None.											

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:
"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
5248.1	FISS reason code 31323 is expected to be impacted by this requirement.

B. All other recommendations and supporting information: This instruction will remove an unnecessary manual step from the medical review process for demand bills, reducing contractor workload slightly.

V. CONTACTS

Pre-Implementation Contact(s): Wil Gehne (410) 786-6148

Post-Implementation Contact(s): Appropriate Regional Office

VI. FUNDING

A. *For Fiscal Intermediaries, Carriers, and the Durable Medical Equipment Regional Carrier (DMERC)*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

B. *For Medicare Administrative Contractors (MAC)*:

The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). 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.

60.3.2 - General Demand Billing Instructions, Inpatient and Outpatient (Other than HH PPS and Part A SNF)

(Rev.1169, Issued: 02-02-07, Effective: 07-01-07, Implementation: 07-02-07)

In addition to current home health and SNF requirements, all other provider types, including HH service NOT paid under HH PPS (i.e., TOB 34x), AND inpatient services (TOBS 11x, 21x, 18x and 41x) are required to submit demand bills using condition code 20 when requested by beneficiaries. Traditionally, hospices are the only other category of providers that have received specific guidance from FIs/RHHIs on using this type of demand bill. FIs/RHHIs perform review of such bills, for reasons such as medical necessity, coverage and payment liability issues, although inpatient hospital bills (TOB 11x) are sent to the quality improvement organizations (QIOs), formerly the peer review organizations (PROs), for medical necessity determinations exclusively.

However, for other outpatient billing, this is ONLY in cases when an ABN is not given/not appropriate (for ABN instructions, see §60.4.1 below). Also, services that the provider is sure are noncovered, such as statutory exclusions outside a recognized Medicare benefit, should never be demand billed through this process UNLESS specifically requested by a beneficiary (i.e., the beneficiary wants a determination, not just billing for denial). Either interim bills, final bills or adjustment requests may be used to demand bill.

Other covered services may appear on these claims, but not other noncovered charges, as all noncovered charges on demand bills will be considered in dispute and in need of review. Allowing covered and noncovered services to come in on demand bills will allow all services provided in the statement covers period to be billed, though payment of the covered services will be delayed by the review and development of the noncovered charges. For this reason, providers should break out demand billed services to separate claims for discrete time periods with all noncovered charges whenever possible. Such claims must contain at least one noncovered charge at issue *when they are received from the provider*, or the claims with condition code 20 will be returned to the provider.

Funds may be collected from beneficiaries in advance of the determination of liability resulting from medical review of a demand bill (note exception for SNFs in §60.3.1.b immediately above). If the result of such review is that the beneficiary is not liable, as when Medicare pays covered charges, any funds collected in advance must be returned.

Additionally, providers may not collect funds from beneficiaries or subsequent insurers for services for which they know they will be found liable. That is, demand billing cannot be used as a red herring to hold or retain either beneficiary or subsequent insurer funds for any period of time when the provider has reason to know they are fully liable for the services in question.

In summary, other general requirements for demand bills, other than SNF and HH PPS demand bill exceptions, are:

- Condition code 20 must be used;
- All charges associated with condition code 20 must be submitted as noncovered, all noncovered services on the demand bill must be in dispute, and at least one noncovered line must appear on the claim, but unrelated covered charges must be allowed on the

same claim (unrelated noncovered charges not in dispute, if any, would be billed on a no payment claim using condition code 21 for outpatient bill types—see III. B. above);

- Frequency code zero should be used if all services on the claim are noncovered;
- Conditions codes 20 and 32 (i.e., ABN) are NEVER submitted on the same claim; and
- Basic required claim elements must be completed.

Claims not meeting these requirements will be returned to providers. Unlike entirely noncovered outpatient claims using condition code 21, no claims may be submitted simultaneously with demand bills, EXCEPT no payment claims for outpatient bill types using condition code 21, with statement period equal to or fitting within the demand bill statement period. This is true even if only charges associated with the condition code 20 are submitted on the claim, and therefore it is an entirely noncovered claim. No payment bills using condition code 21 are only used for services that are not in dispute, as opposed to noncovered charges on demand bills. This restriction is required because some services on demand bills may be found covered upon review, unlike no payment claims where there is no expectation of coverage/payment. Avoiding overlaps with other than entirely no payment claims will also prevent rejection as duplicates. If received, the incoming overlapping claim using condition code 20 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.

Also new with this instruction, providers should be aware CMS may require development of any noncovered charge on traditional demand bills. In addition to this review, such services will then be paid, RTP'ed, rejected or denied in accordance with other instructions/edits applied in processing to completion.