CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2783	**Date: September 10, 2013**
	Change Request 8343

Transmittal 2725, dated June 14, 2013 is being rescinded and replaced by Transmittal 2783, dated September 10, 2013, to restore erroneously deleted section 60.1.1 to the chapter and to correctly delete section 60.1.1.1 from the chapter. Also, the effective and implementation dates are being revised to September 30, 2013. All other information remains the same.

SUBJECT: Corrections to the Medicare Claims Processing Manual

I. SUMMARY OF CHANGES: This Change Request makes various corrections to chapters of the Medicare Claims Processing Manual.

EFFECTIVE DATE: September 30, 2013
IMPLEMENTATION DATE: September 30, 2013

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	1/01/Foreword
N	1/60.1.1/Basic Payment Liability Conditions
D	1/60.1.1.1/Liability Considerations for Bundled Services
R	1/60.4.2/Line-Item Modifiers Related to Reporting of Non-covered Charges When Covered and Non-covered Services Are on the Same Outpatient Claim
N	1/60.4.3/Liability Considerations for Bundled Services
R	1/60.5/Coding That Results from Processing Noncovered Charges
R	5/10.4/Claims Processing Requirements for Financial Limitations
R	23/50.6/Physician Fee Schedule Payment Policy Indicator File Record Layout
R	32/80.1/General Billing Requirements
R	32/80.4/Payment

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	32/80.7/CWF General Information

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; contractor's activities are to be carried out within their operating budgets.

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 obliged 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

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 2783	Date: September 10,2013	Change Request: 8343

Transmittal 2725, dated June 14, 2013 is being rescinded and replaced by Transmittal 2783, dated September 10, 2013, to restore erroneously deleted section 60.1.1 to the chapter and to correctly delete section 60.1.1.1 from the chapter. Also, the effective and implementation dates are being revised to September 30, 2013. All other information remains the same.

SUBJECT: Corrections to the Medicare Claims Processing Manual

EFFECTIVE DATE: September 30, 2013

IMPLEMENTATION DATE: September 30, 2013

I. GENERAL INFORMATION

A. Background: This Change Request (CR) makes corrections to four chapters of Pub. 100-04, Medicare Claims Processing Manual.

1) CR 8128 revised the layouts of a number of Original Medicare's fee schedule abstract files to add an effective date. During implementation of this CR, Medicare discovered that one file, the payment indicator file, was not updated correctly in the manual. System changes to accommodate an effective date on the payment indicator file were made with CR 8128, on the assumption that a manual correction would follow soon after. This CR makes the needed correction to Chapter 23.

2) Medicare coverage of the diagnosis and treatment of peripheral neuropathy with loss of protective sensation in people with diabetes was established under the physician services benefit category. When claims instructions for these services were added to Chapter 32, instructions for billing the service on rehabilitation agency claims (type of bill 74X) and Comprehensive Outpatient Rehabilitation Facility claims (type of bill 75X) were included in error. This CR revised Chapter 32 to remove instructions for these types of bill. Medicare data indicate these services have not been paid on claims for these providers, so this correction will have no impact on provider billing practices.

3) Chapter 1 is revised to add a definition of institutional vs. professional claims. Additionally, section 60 regarding non-covered charges is revised to make several corrections. References to modifier -TS are removed, since other instructions have established the use of the modifier on covered services. Section 60.1.1 had been misplaced in an earlier transmittal. This information is replaced in its original position as a sub-section under section 60.4. Remittance advice codes for use with modifier -GZ, which had been created in CR 7228, are manualized.

4) Chapter 5 is revised to correct a reference regarding liability for services denied under the therapy cap.

B. Policy: This CR contains no policy changes.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
8343.1	Medicare contractors shall be aware of the corrections to Pub. 100-04 contained in this Change Request.	X				X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility							
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Other
		A	B	HHH					
	None								

IV. SUPPORTING INFORMATION

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

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): Wil Gehne, wilfried.gehne@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:
No additional funding will be provided by CMS; contractor's activities are to be carried out within their operating budgets.

Section B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS do 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.

Medicare Claims Processing Manual

Chapter 1 - General Billing Requirements

Table of Contents
(Rev. 2783, Issued: 09-10-13)

01 - Foreword

(Rev. 2783, Issued: 09-10-13, Effective: 09-30-13, Implementation: 09-30-13)

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 X12N 837 - Health Care Claim: Institutional or the UB-04 paper claim form.*

- *Professional claim means any claim submitted using the HIPAA mandated transaction ASC X12N 837 - Health Care Claim: Professional or the CMS-1500 paper claim form.*

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,*	*Items and services being billed are either a reduction or termination of Medicare coverage, or are otherwise*	*Items or service is presumed to be a Medicare benefit and can be paid.*

	meaning it is not defined as a specific Medicare benefit defined in the Act; therefore, it is never paid.	*expected to be denied, leaving financial liability for a beneficiary or 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	*Home Health (HH) services under a HH plan of care and paid through the HH prospective payment system*	*HHABNs (Form CMS-R-296) required.*

IS required and liability expected	*(PPS) only (TOBs 32x and 33X)*	
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.

60.4.2 - 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

Mod-ifier	**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
-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

Mod-ifier	HCPCS Modifier Definition	HCPCS Coverage/ Payment/ Administrative Instruction	Notice Requirement/ Liability	Billing Use	Payment Result
-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
-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

Mod-ifier	HCPCS Modifier Definition	HCPCS Coverage/ Payment/ Administrative Instruction	Notice Requirement/ Liability	Billing Use	Payment Result
-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. 2783, Issued: 09-10-13, Effective: 09-30-13, Implementation: 09-30-13)

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.

Unless more specific requirements apply, the following remittance and MSN messages can be used for denied noncovered charges on Medicare claims.

Liability	Remittance Requirement	MSN Message
Beneficiary	Group Code PR for patient responsibility, *claim adjustment reason code (CARC)* 96 for noncovered charges	16.10 "Medicare does not pay for this item or service."; OR, "Medicare no paga por este artículo o servicio."
Provider	Group Code CO for contractual obligation, *CARC* 96 for noncovered charges	16.58 "The provider billed this charge as noncovered. You do not have to pay this amount."; OR, "El proveedor facuró este cargo como no cubierto. Usted no tiene que pagar ests cantidad."

When services are submitted with the modifier GZ and are denied, contractors shall use the following codes: Group Code CO, CARC 50 (defined "These services are non-covered services because this is not deemed a 'medical necessity' by the payer") and MSN Message 8.81.

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: • 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	• Charges are shown as noncovered ; • neither utilization nor cost report days are reported.

	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).	
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.

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Chapter 5 - Part B Outpatient Rehabilitation and CORF/OPT Services

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10.4 - Claims Processing Requirements for Financial Limitations

(Rev. 2783, Issued: 09-10-13, Effective: 09-30-13, Implementation: 09-30-13)

A. Requirements – Institutional Claims

Regardless of financial limits on therapy services, CMS requires modifiers (See section 20.1 of this chapter) on specific codes for the purpose of data analysis. Beneficiaries may not be simultaneously covered by Medicare as an outpatient of a hospital and as a patient in another facility. When outpatient hospital therapy services are excluded from the limitation, the beneficiary must be discharged from the other setting and registered as a hospital outpatient in order to receive payment for outpatient rehabilitation services in a hospital outpatient setting after the limitation has been reached.

A hospital may bill for services of a facility as hospital outpatient services if that facility meets the requirements of a department of the provider (hospital) under 42 CFR 413.65. Facilities that do not meet those requirements are not considered to be part of the hospital and may not bill under the hospital's provider number, even if they are owned by the hospital. For example, services of a Comprehensive Outpatient Rehabilitation Facility (CORF) must be billed as CORF services and not as hospital outpatient services, even if the CORF is owned by the hospital. Only services billed by the hospital on bill types 12X or 13X are exempt from limitations on therapy services, when outpatient hospital therapy services are excluded from the limitation.

The CWF applies the financial limitation to the following bill types 22X, 23X, 34X, 74X and 75X using the MPFS allowed amount (before adjustment for beneficiary liability).

For SNFs, the financial limitation does apply to rehabilitation services furnished to those SNF residents in noncovered stays (bill type 22X) who are in a Medicare-certified section of the facility—i.e., one that is either certified by Medicare alone, or is dually certified by Medicare as a SNF and by Medicaid as a nursing facility (NF). For SNF residents, consolidated billing requires all outpatient rehabilitation services be billed to Part B by the SNF. If a resident has reached the financial limitation, and remains in the Medicare-certified section of the SNF, no further payment will be made to the SNF or any other entity. Therefore, SNF residents who are subject to consolidated billing may not obtain services from an outpatient hospital after the cap has been exceeded.

Once the financial limitation has been reached, *services furnished to* SNF residents who are in a non-Medicare certified section of the facility—i.e., one that is certified only by Medicaid as a NF or that is not certified at all by either program—use bill type 23X. For SNF residents in non-Medicare certified portions of the facility and SNF nonresidents who go to the SNF for outpatient treatment (bill type 23X), medically necessary outpatient therapy may be covered at an outpatient hospital facility after the financial limitation has been exceeded when outpatient hospital therapy services are excluded from the limitation.

B. Requirements - *Professional* Claims

Claims containing any of the "always therapy" codes should have one of the therapy modifiers appended (GN, GO, GP). When any code on the list of therapy codes is submitted with specialty codes "65" (physical therapist in private practice), "67" (occupational therapist in private practice), or "15" (speech-language pathologist in private practice) they always represent therapy services, because they are provided by therapists. *Contractors* shall return claims for these services when they do not contain therapy modifiers for the applicable HCPCS codes.

The CMS identifies certain codes listed at: http://www.cms.hhs.gov/TherapyServices/05_Annual_Therapy_Update.asp#TopOfPage as "sometimes therapy" services, regardless of the presence of a financial limitation. Claims from physicians (all specialty codes) and nonphysician practitioners, including specialty codes "50" (Nurse Practitioner), "89," (Clinical

Nurse Specialist), and "97," (Physician Assistant) may be processed without therapy modifiers when they are not therapy services. On review of these claims, "sometimes therapy" services that are not accompanied by a therapy modifier must be documented, reasonable and necessary, and payable as physician or nonphysician practitioner services, and not services that the contractor interprets as therapy services.

The CWF will capture the amount and apply it to the limitation whenever a service is billed using the GN, GO, or GP modifier.

C. *Contractor* Action Based on CWF Trailer

Upon receipt of the CWF error code/trailer, *contractors* are responsible for assuring that payment does not exceed the financial limitations, when the limits are in effect, except as noted below.

In cases where a claim line partially exceeds the limit, the *contractor* must adjust the line based on information contained in the CWF trailer. For example, where the MPFS allowed amount is greater than the financial limitation available, always report the MPFS allowed amount in the "Financial Limitation" field of the CWF record and include the CWF override code. See example below for situations where the claim contains multiple lines that exceed the limit.

EXAMPLE:

Services received to date are $15 under the limit. There is a $15 allowed amount remaining that Medicare will cover before the cap is reached.

Incoming claim: Line 1 MPFS allowed amount is $50.
Line 2 MPFS allowed amount is $25.
Line 3, MPFS allowed amount is $30.

Based on this example, lines 1 and 3 are denied and line 2 is paid. The *contractor* reports in the "Financial Limitation" field of the CWF record "$25.00 along with the CWF override code. The *contractor* always applies the amount that would least exceed the limit. Since *institutional claims* systems cannot split the payment on a line, CWF will allow payment on the line that least exceeds the limit and deny other lines.

D. Additional Information for Contractors During the Time Financial Limits Are in Effect With or Without Exceptions

Once the limit is reached, if a claim is submitted, CWF returns an error code stating the financial limitation has been met. Over applied lines will be identified at the line level. The outpatient rehabilitation therapy services that exceed the limit should be denied. The contractors use claim adjustment reason code 119 - Benefit maximum for this time period or occurrence has been reached- in the provider remittance advice to establish the reason for denial. *Provider liability (group code CO) or beneficiary liability (group code PR) are reported on the remittance advice as defined by section 10.5.*

In situations where a beneficiary is close to reaching the financial limitation and a particular claim might exceed the limitation, the provider/supplier should bill the usual and customary charges for the services furnished even though such charges might exceed the limit. The CWF will return an error code/trailer that will identify the line that exceeds the limitation.

Because CWF applies the financial limitation according to the date when the claim was received (when the date of service is within the effective date range for the limitation), it is possible that the financial limitation will have been met before the date of service of a given claim. Such claims will prompt the CWF error code and subsequent contractor denial.

When the provider/supplier knows that the limit has been reached, and exceptions are either not appropriate or not available, further billing should not occur. The provider/supplier should inform the beneficiary of the limit and their option of receiving further covered services from an outpatient hospital when outpatient hospital therapy services are excluded from the limitation (unless consolidated billing rules prevent the use of the outpatient hospital setting). If the beneficiary chooses to continue treatment at a setting other than the outpatient hospital where medically necessary services may be covered, the services may be billed at the rate the provider/supplier determines. Services provided in a capped setting after the limitation has been reached are not Medicare benefits and are not governed by Medicare policies.

If a beneficiary elects to receive services that exceed the cap limitation and a claim is submitted for such services, the resulting determination is subject to the administrative appeals process as described in subsection C. of section 10.3 and Pub. 100-04, chapter 29.

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Chapter 23 - Fee Schedule Administration and Coding Requirements

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50.6 – Physician Fee Schedule Payment Policy Indicator File Record Layout

(Rev. 2783, Issued: 09-10-13, Effective: 09-30-13, Implementation: 09-30-13)

The information on the Physician Fee Schedule Payment Policy Indicator file record layout is used for processing Method II CAH professional services with revenue codes 96X, 97X or 98X.

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
File Year This field displays the effective year of the file.	4 Pic x(4)	1-4
HCPCS Code This field represents the procedure code. Each Current Procedural Terminology (CPT) code and alpha-numeric HCPCS codes A, C, T, and some R codes that are currently returned on the MPFS supplemental file will be included. The standard sort for this field is blanks, alpha, and numeric in ascending order.	5 Pic x(5)	5-9
Modifier For diagnostic tests, a blank in this field denotes the global service and the following modifiers identify the components: 26 = Professional component; and TC = Technical component. For services other than those with a professional and/or technical component, a blank will appear in this field with one exception: the presence of CPT modifier -53 which indicates that separate Relative Value Units (RVUs) and a fee schedule amount have been established for procedures which the physician terminated before completion. This modifier is used only with colonoscopy code 45378 and screening colonoscopy codes G0105 and G0121. Any other codes billed with modifier -53 are subject to medical review and priced by individual consideration. Modifier-53 = Discontinued Procedure - Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances, or those that threaten the well being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued.	2 Pic x(2)	10-11
Code Status This 1 position field provides the status of each code under the full fee schedule. Each status code is explained in Pub. 100-04, Chapter 23, §30.2.2.	1 Pic x(1)	12
Global Surgery	3 Pic x(3)	13-15

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
This field provides the postoperative time frames that apply to payment for each surgical procedure or another indicator that describes the applicability of the global concept to the service. 000 = Endoscopic or minor procedure with related preoperative and postoperative relative values on the day of the procedure only included in the fee schedule payment amount; evaluation and management services on the day of the procedure generally not payable. 010 = Minor procedure with preoperative relative values on the day of the procedure and postoperative relative values during a 10-day postoperative period included in the fee schedule amount; evaluation and management services on the day of the procedure and during this 10-day postoperative period generally not payable. 090 = Major surgery with a 1-day preoperative period and 90-day postoperative period included in the fee schedule payment amount. MMM = Maternity codes; usual global period does not apply. XXX = Global concept does not apply. YYY = Fiscal intermediary (FI) determines whether global concept applies and establishes postoperative period, if appropriate, at time of pricing. ZZZ = Code related to another service and is always included in the global period of the other service. (**NOTE**: Physician work is associated with intra-service time and in some instances the post service time.)		
Preoperative Percentage (Modifier 56) This field contains the percentage (shown in decimal format) for the preoperative portion of the global package. For example, 10 percent will be shown as 010000. The total of the preoperative percentage, intraoperative percentage, and the postoperative percentage fields will usually equal one. Any variance is slight and results from rounding.	6 Pic 9v9(5)	16-21
Intraoperative Percentage (Modifier 54)	6 Pic 9v9(5)	22-27

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
This field contains the percentage (shown in decimal format) for the intraoperative portion of the global package including postoperative work in the hospital. For example, 63 percent will be shown as 063000. The total of the preoperative percentage, intraoperative percentage, and the postoperative percentage fields will usually equal one. Any variance is slight and results from rounding.		
Postoperative Percentage (Modifier 55) This field contains the percentage (shown in decimal format) for the postoperative portion of the global package that is provided in the office after discharge from the hospital. For example, 17 percent will be shown as 017000. The total of the preoperative percentage, intraoperative percentage, and the postoperative percentage fields will usually equal one. Any variance is slight and results from rounding.	6 Pic 9v9(5)	28-33
Professional Component (PC)/Technical Component (TC) Indicator 0 = Physician service codes: This indicator identifies codes that describe physician services. Examples include visits, consultations, and surgical procedures. The concept of PC/TC does not apply since physician services cannot be split into professional and technical components. Modifiers 26 & TC cannot be used with these codes. The total Relative Value Units (RVUs) include values for physician work, practice expense and malpractice expense. There are some codes with no work RVUs. 1 = Diagnostic tests or radiology services: This indicator identifies codes that describe diagnostic tests, e.g., pulmonary function tests, or therapeutic radiology procedures, e.g., radiation therapy. These codes generally have both a professional and technical component. Modifiers 26 and TC can be used with these codes. The total RVUs for codes reported with a 26 modifier include values for physician work, practice expense, and malpractice expense. The total RVUs for codes reported with a TC modifier include values for practice expense and malpractice expense only. The total RVUs for codes reported without a modifier equals the sum of RVUs	1 Pic x(1)	34

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
for both the professional and technical component. 2 = Professional component only codes: This indicator identifies stand alone codes that describe the physician work portion of selected diagnostic tests for which there is an associated code that describes the technical component of the diagnostic test only and another associated code that describes the global test. An example of a professional component only code is 93010, Electrocardiogram; interpretation and report. Modifiers 26 and TC cannot be used with these codes. The total RVUs for professional component only codes include values for physician work, practice expense, and malpractice expense. 3 = Technical component only codes: This indicator identifies stand alone codes that describe the technical component (i.e., staff and equipment costs) of selected diagnostic tests for which there is an associated code that describes the professional component of the diagnostic tests only. An example of a technical component code is 93005, Electrocardiogram, tracing only, without interpretation and report. It also identifies codes that are covered only as diagnostic tests and therefore do not have a related professional code. Modifiers 26 and TC cannot be used with these codes. The total RVUs for technical component only codes include values for practice expense and malpractice expense only. 4 = Global test only codes: This indicator identifies stand alone codes for which there are associated codes that describe: a) the professional component of the test only and b) the technical component of the test only. Modifiers 26 and TC cannot be used with these codes. The total RVUs for global procedure only codes include values for physician work, practice expense, and malpractice expense. The total RVUs for global procedure only codes equals the sum of the total RVUs for the professional and technical components only codes combined. 5 = Incident to Codes: This indicator identifies codes that describe services covered incident to a physicians service when they are provided by auxiliary personnel employed by the physician and		

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
working under his or her direct supervision. Payment may not be made by carriers for these services when they are provided to hospital inpatients or patients in a hospital outpatient department. Modifiers 26 and TC cannot be used with these codes. 6 = Laboratory physician interpretation codes: This indicator identifies clinical laboratory codes for which separate payment for interpretations by laboratory physicians may be made. Actual performance of the tests is paid for under the lab fee schedule. Modifier TC cannot be used with these codes. The total RVUs for laboratory physician interpretation codes include values for physician work, practice expense and malpractice expense. 7 = Physical therapy service: Payment may not be made if the service is provided to either a hospital outpatient or inpatient by an independently practicing physical or occupational therapist. 8 = Physician interpretation codes: This indicator identifies the professional component of clinical laboratory codes for which separate payment may be made only if the physician interprets an abnormal smear for hospital inpatient. This applies only to code 85060. No TC billing is recognized because payment for the underlying clinical laboratory test is made to the hospital, generally through the PPS rate. No payment is recognized for code 85060 furnished to hospital outpatients or non-hospital patients. The physician interpretation is paid through the clinical laboratory fee schedule payment for the clinical laboratory test. 9 = Concept of a professional/technical component does not apply		
Multiple Procedure (Modifier 51) Indicator indicates which payment adjustment rule for multiple procedures applies to the service. 0 = No payment adjustment rules for multiple procedures apply. If the procedure is reported on the same day as another procedure, base payment on the lower of: (a) the actual charge or (b) the fee schedule amount for the procedure. 1 = Standard payment adjustment rules in effect before January 1, 1996, for multiple procedures	1 Pic (x)1	35

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
apply. In the 1996 MPFSDB, this indicator only applies to codes with procedure status of "D." If a procedure is reported on the same day as another procedure with an indicator of 1,2, or 3, rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100 percent, 50 percent, 25 percent, 25 percent, 25 percent, and by report). Base payment on the lower of: (a) the actual charge or (b) the fee schedule amount reduced by the appropriate percentage. 2 = Standard payment adjustment rules for multiple procedures apply. If the procedure is reported on the same day as another procedure with an indicator of 1, 2, or 3, rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100 percent, 50 percent, 50 percent, 50 percent, 50 percent, and by report). Base payment on the lower of: (a) the actual charge or (b) the fee schedule amount reduced by the appropriate percentage. 3 = Special rules for multiple endoscopic procedures apply if procedure is billed with another endoscopy in the same family (i.e., another endoscopy that has the same base procedure). The base procedure for each code with this indicator is identified in the endoscopic base code field. Apply the multiple endoscopy rules to a family before ranking the family with other procedures performed on the same day (for example, if multiple endoscopies in the same family are reported on the same day as endoscopies in another family or on the same day as a non-endoscopic procedure). If an endoscopic procedure is reported with only its base procedure, do not pay separately for the base procedure. Payment for the base procedure is included in the payment for the other endoscopy. 4 = Subject to MPPR reduction. 9 = Concept does not apply.		
Bilateral Surgery Indicator (Modifier 50) This field provides an indicator for services subject to a payment adjustment. 0 = 150 percent payment adjustment for bilateral procedures does not apply.	1 Pic (x)1	36

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
The bilateral adjustment is inappropriate for codes in this category because of: (a) physiology or anatomy, or (b) because the code descriptor specifically states that it is a unilateral procedure and there is an existing code for the bilateral procedure. 1 = 150 percent payment adjustment for bilateral procedures applies. If code is billed with the bilateral modifier base payment for these codes when reported as bilateral procedures on the lower of: (a) the total actual charge for both sides, or (b) 150 percent of the fee schedule amount for a single code. If code is reported as a bilateral procedure and is reported with other procedure codes on the same day, apply the bilateral adjustment before applying any applicable multiple procedure rules. 2 = 150 percent payment adjustment for bilateral procedure does not apply. RVUs are already based on the procedure being performed as a bilateral procedure. The RVUs are based on a bilateral procedure because: (a) the code descriptor specifically states that the procedure is bilateral; (b) the code descriptor states that the procedure may be performed either unilaterally or bilaterally; or (c) the procedure is usually performed as a bilateral procedure. 3 = The usual payment adjustment for bilateral procedures does not apply. Services in this category are generally radiology procedures or other diagnostic tests which are not subject to the special payment rules for other bilateral procedures. If a procedure is billed with the 50 modifier, base payment on the lesser of the total actual charges for **each** side or 100% of the fee schedule amount for **each** side. 9 = Concept does not apply.		
Assistant at Surgery (Modifiers AS, 80, 81 and 82) This field provides an indicator for services where an assistant at surgery may be paid: 0 = Payment restriction for assistants at surgery applies to this procedure unless supporting	1 Pic (x)1	37

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
documentation is submitted to establish medical necessity. 1 = Statutory payment restriction for assistants at surgery applies to this procedure. Assistant at surgery may not be paid. 2 = Payment restriction for assistants at surgery does not apply to this procedure. Assistant at surgery may be paid. 9 = Concept does not apply.		
Co-Surgeons (Modifier 62) This field provides an indicator for services for which two surgeons, each in a different specialty, may be paid. 0 = Co-surgeons not permitted for this procedure. 1 = Co-surgeons could be paid; supporting documentation required to establish medical necessity of two surgeons for the procedure. 2 = Co-surgeons permitted; no documentation required if two specialty requirements are met. 9 = Concept does not apply.	1 Pic (x)1	38
Team Surgeons (Modifier 66) This field provides an indicator for services for which team surgeons may be paid. 0 = Team surgeons not permitted for this procedure. 1 = Team surgeons could be paid; supporting documentation required to establish medical necessity of a team; pay by report. 2 = Team surgeons permitted; pay by report. 9 = Concept does not apply.	1 Pic (x)1	39
Endoscopic Base Codes This field identifies an endoscopic base code for each code with a multiple surgery indicator of 3.	5 Pic (x) 5	40-44
Performance Payment Indicator (For future use)	1 Pic x (1)	45
Diagnostic Imaging Family Indicator 88 = Subject to the reduction for diagnostic imaging (effective for services January 1, 2011, and after).	2 Pic x (2)	46-47

FIELD NAME & DESCRIPTION	LENGTH & PIC	Position
99 = Concept Does Not Apply		
Effective Date *This field displays the effective date of the file in YYYYMMDD format.*	*8 Pic x(8)*	*48 - 55*
Filler	*30 Pic x(30)*	*56 -75*

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Chapter 32 – Billing Requirements for Special Services

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(Rev. 2783, Issued: 09-10-13)

80.1 - General Billing Requirements

(Rev. 2783, Issued: 09-10-13, Effective: 09-30-13, Implementation: 09-30-13)

The following providers of service may bill you for these services:

Hospitals;
Critical Access Hospitals
Rural Health *Clinics; and*
Free-Standing Federally Qualified Health *Clinics* (FQHC).

80.4 - Payment

(Rev. 2783, Issued: 09-10-13, Effective: 09-30-13, Implementation: 09-30-13)

- Hospital outpatient departments – OPPS
- Critical Access Hospital (CAH) - Method I -- Reasonable cost; Method II -- Technical - reasonable cost, Professional -- 115 percent of the fee schedule
- Rural Health Clinics/Federally Qualified Health Centers (RHCs/FQHCs) - All inclusive rate.

Deductible and coinsurance apply.

While these physician services may be appropriately provided to patients of Comprehensive Outpatient Rehabilitation Facilities (CORFs), the CORF does not bill. The services are billed by the physician on a professional claim.

Examples of Payment calculation:

Part B Deductible Met: $900 (MPFS allowed amount) x 20 percent (co-insurance) = $720 (Medicare reimbursement). Beneficiary is responsible for $180.
Part B Deductible Not met: $900 (MPFS allowed amount) - $100 (Part B deductible) = $800 x 20 percent (co-insurance) = $640 (Medicare reimbursement). Beneficiary is responsible for $260.
Part B Deductible Met: $800 (actual charged amount) x 20 percent (co-insurance) = $640 (Medicare Reimbursement), beneficiary is responsible for $160 co-insurance.
Part B Deductible Not Met: $800 (actual charged amount) - $100 (Part B deductible) = $700 x 20 percent (co-insurance) = $560 (Medicare reimbursement). Beneficiary is responsible for $240, ($100 Part B deductible and $140 co-insurance).
Services are paid at 80 percent of the lesser of the fee schedule amount or the actual charges.

This service, when furnished in an RHC/FQHC by a physician or non-physician, is considered an RHC/FQHC service. RHCs/FQHCs bill you under bill type 71X or 73X with revenue code 940 and HCPCS G0245, G0246, and G0247.
Payment should not be made for this service unless the claim contains a related visit code. Therefore, install an edit in your system to assure payment is not made for revenue code 940 unless the claim also contains a visit revenue code (520 or 521).

Applicable Revenue Codes

The applicable revenue code is 940, except for hospitals.

This service can be performed in other revenue centers such as a clinic (510) for hospitals. Therefore, instruct your hospitals to report these procedures under the revenue center where they are performed.

80.7 - CWF General Information

(Rev. 2783, Issued: 09-10-13, Effective: 09-30-13, Implementation: 09-30-13)

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 beneficiary Health Insurance Claim number 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.