CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 4286	**Date: April 26, 2019**
	Change Request 11221

SUBJECT: Update to Chapter 21 in Publication (Pub.) 100-04 to Provide Language-Only Changes for the New Medicare Card Project

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update Chapter 21 in Pub. 100-04 with the New Medicare Card Project-related language. 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: May 28, 2019
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: May 28, 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	21/10/10.3.3/Specifications for Section 1: Summary (Page 1)
R	21/20/20.1/Specifications for Content Variations of Spanish MSNs

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: 4286	Date: April 26, 2019	Change Request: 11221

SUBJECT: Update to Chapter 21 in Publication (Pub.) 100-04 to Provide Language-Only Changes for the New Medicare Card Project

EFFECTIVE DATE: May 28, 2019
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: May 28, 2019

I. GENERAL INFORMATION

A. Background: The 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 Chapter 21 of Pub. 100-04.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires removal of the 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.

B. Policy: MACRA of 2015.

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	
11221.1	MACs shall be aware of the updated language for the New Medicare Card Project in Chapter 21 of Pub. 100-04.	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): Kim Davis, 410-786-4721 or kimberly.davis@cms.hhs.gov, Tracey Mackey, 410-786-5736 or Tracey.Mackey@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

10.3.3 - Specifications for Section 1: Summary (Page 1)

(Rev.4286, Issued: 04-26-19, Effective: 05-28-19, Implementation: 05-28-19)

A. Notice Title

This section names the notice, specifies the function of the notice and the Medicare program under which the notice's claims are paid, and identifies the Federal agencies responsible for generating the notice.

GLOBAL SPECIFICATIONS

POSITION

This subsection contains information of a fixed size. It does not vary in overall width or length.

The content area begins (0″, 0″), and is full page or 540 points in width, 72 points in height.

The Department of Health & Human Services seal, a flash image, is 72 points by 72 points. Indent 9 points from the seal to start the three text elements.

MACs are not to change the format of the Notice Title subsection in order to use double window envelopes.

figure 10.3.3.A1

figure 10.3.3.A2

FORMATTING
[GL 1] DHHS Seal
[TH 1.1] notice title
[TH 1.2] notice subtitle, indicating to which Medicare program the notice relates
[TB 3] notice descriptive tagline
NOTE: Pagination specification on next subsection
NOTE: Use [TH 1.3] or [TH1.4] instead of [TH 1.2] for combined subtitle to fit in one line.
NOTE: Use [TH 1.4] only if using [TH 1.3] for combined subtitle will not fit in one line.

DYNAMIC RULES

The notice subtitle is dynamically generated based on which type(s) of claims are present on the MSN:

- Only claims paid by the Part A program;
- Part B, 'B of A', or DME claims - all of which are paid by the Part B program; or

- A combination of Part A Inpatient and ‘B of A’ claims that are paid by both Part A and Part B.

PART A INPATIENT, HOSPICE, AND HOME HEALTH (A) SPECIFICATIONS

CONTENT

Notices with only claims paid by the Part A program should have text content as follows:

Medicare Summary Notice
for Part A (Hospital Insurance)
The Official Summary of Your Medicare Claims from the Centers for Medicare & Medicaid Services

PART B (ASSIGNED & UNASSIGNED), HOME HEALTH (B), ‘B OF A’, AND DME SPECIFICATIONS
CONTENT
Notices with only claims paid by the Part B program should have text content as follows:

Medicare Summary Notice
for Part B (Medical Insurance)
The Official Summary of Your Medicare Claims from the Centers for Medicare & Medicaid Services

COMBINED PART A INPATIENT AND ‘B OF A’ SPECIFICATIONS

CONTENT

Notices that include both claims paid by the Part A program and also claims paid by the Part B programs - as on notices that have both inpatient hospital claims and outpatient ‘B of A’ claims - should have text content as follows:

Medicare Summary Notice
for Part A (Hospital Insurance) and Part B (Medical Insurance)
The Official Summary of Your Medicare Claims from the Centers for Medicare & Medicaid Services

B. Pagination

The page number indicator, in the format Page 1 of #, must include the dynamically generated total page count for the notice in the second numeric position. Refer to specimen on section A for type style and placement relative to Notice title.

NOTE: This specification is for pagination on page 1 only. See section 10.3.4 for pagination included on page header for other pages.

POSITION

This subsection contains information of a fixed size. It does not vary in overall height but may vary in width depending on total page count.

The content area begins (0″, 6.75″), right aligned from right margin. It is 90 points in width, 11 points in height.

FORMATTING
[TB 2.1] all text, right aligned

C. Recipient Address

POSITION

This subsection contains information of a variable size.

The content area begins (0″, 1.35″) with 32 point indent from left margin. It is 1-column or 259 points in width with variable height, from 3 to 6 lines of text, not to exceed 82 points at 6 lines.

The name and address information is listed with 9-point clearance around the address when inserted into window envelope, to meet U.S. Postal Service regulations. For specifications on window size and position, see section 10.3.10.

The position may vary for envelope to align with the recipient address of the inserted MSN. Depending on the alignment, the address field of the printed MSN may be adjusted for ideal positioning.

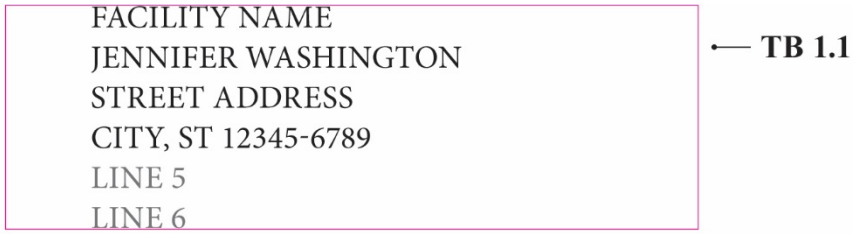

figure 10.3.3.C1

[The below figure is new.]

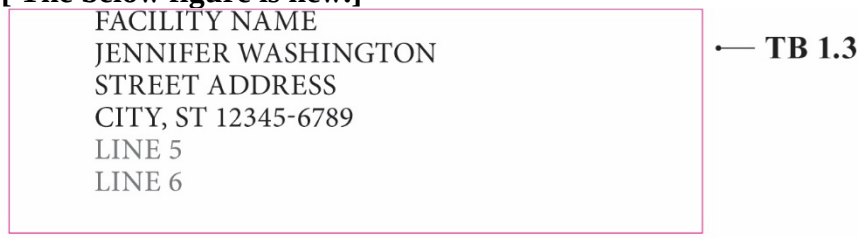

figure 10.3.3.C2

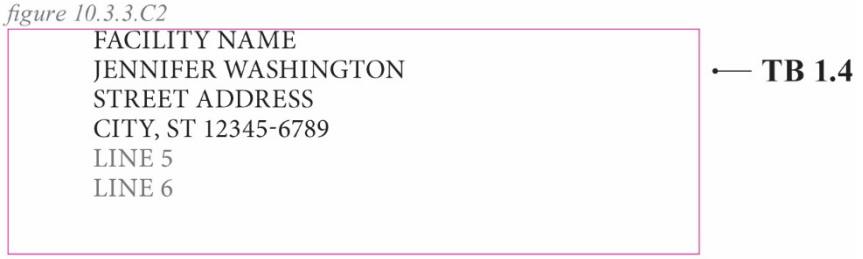

figure 10.3.3.C3

FORMATTING
[TB 1.1] all text, all caps

NOTE: MACs may also use a smaller font size [TB 1.3] or [TB 1.4] if needed.

DYNAMIC RULES

All of the content in this subsection is dynamically generated.

At minimum, the beneficiary name and one- or two-line mailing address should be printed. The name should be printed with the given name first, followed by any middle initial(s), the family name, then any suffixes (e.g., Jr.)

If applicable, when the beneficiary's primary residence is a healthcare facility, a facility name may be appended above the beneficiary's name.

As necessary, a second name (the beneficiary's legal representative) may be added above the beneficiary's name, followed by "for". The name should be printed in bold with the given name first, followed by any middle initial(s), the family name, then any suffixes (e.g., Jr.)

In the case that a legal representative is indicated, the designated recipient's mailing address (if different from the beneficiary's address) should be used instead of the beneficiary's address.

The hierarchy of address should be as follows:

- Legal representative
- Beneficiary's temporary address
- Beneficiary's permanent address

CONTENT

{BENEFICIARY'S GIVEN NAME}{BENEFICIARY'S MIDDLE INITIAL}{BENEFICIARY'S FAMILY NAME}{BENEFICIARY'S SUFFIX}
{PERMANENT STREET ADDRESS}
{SECOND LINE OF STREET ADDRESS}
{CITY}, {STATE ABREVIATION} {ZIP+4}

Or

{BENEFICIARY'S GIVEN NAME}{BENEFICIARY'S MIDDLE INITIAL}{BENEFICIARY'S FAMILY NAME}{BENEFICIARY'S SUFFIX}
{TEMPORARY ADDRESS FACILITY NAME OR STREET ADDRESS}
{SECOND LINE OF STREET ADDRESS}
{CITY}, {STATE ABREVIATION} {ZIP+4}

Or

{LEGAL REPRESENTATIVE'S GIVEN NAME}{LEGAL REPRESENTATIVE'S MIDDLE INITIALS}{LEGAL REPRESENTATIVE'S FAMILY NAME}{LEGAL REPRESENTATIVE'S SUFFIX} FOR
{BENEFICIARY'S GIVEN NAME}{BENEFICIARY'S MIDDLE INITIAL}{BENEFICIARY'S FAMILY NAME}{BENEFICIARY'S SUFFIX}
{LEGAL REPRESENTATIVE'S STREET ADDRESS}
{SECOND LINE OF STREET ADDRESS}
{CITY}, {STATE ABREVIATION} {ZIP+4}

NOTE: Comma between City and State is optional, to follow current practice.

D. Notice Details

This subsection provides a summary of whom the notice is for and what time period it covers.

POSITION

This subsection has a fixed size and position.

The subsection is printed on a gray highlight box. The gray area begins (0″, 2.75″). It is one-column or 259 points in width and 108 points in height.

Indent in 8 points all around to begin content area.

The three lines of body content are organized into static and dynamic text. Static text is in regular text, without changing content. Indent 133 points in from left margin to start dynamic text (e.g., beneficiary's Medicare number) in bold.

figure 10.3.3.D1

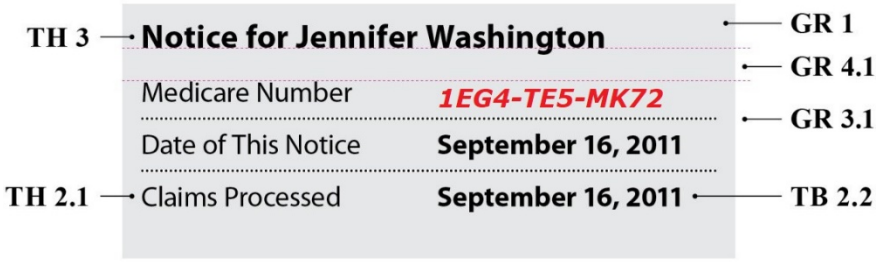

figure 10.3.3.D2

FORMATTING

[GR 1] gray background
[TH 3] notice details header
[GR 4.1] spacing after header
[GR 3.1] dotted rule
[TB 2.1] static body content [TB 2.2] dynamic body content
[GR 3.1] dotted rule
[TB 2.1] static body content [TB 2.2] dynamic body content
[GR 3.1] dotted rule
[TB 2.1] static body content [TB 2.2] dynamic body content

DYNAMIC RULES

This subsection is comprised of four lines; each line has both static and dynamic content.

Notice for…

The first line has the static text "Notice for" followed by the beneficiary's given and family names. Note that for space purposes the middle initial(s) and suffixes should not be included here.

Medicare Number

The second line has a static title and the beneficiary's Medicare number.

When possible, the number should be broken by dashes in the format (e.g., *1EG4-TE5-MK72*).

Date of This Notice

The third line has a static title and the date that the notice was printed. The date is listed with a spelled-out month, numeric day, and complete numeric year (e.g., October 15, 2021).

Claims Processed…

On a typical MSN, the fourth line has a static title, "Claims Processed Between" and dates that represent the start and end dates of the complete claim-processing period. The first date printed should correspond to the first day of the period that was reviewed for claims prior to the generation of the notice. The final date printed should reflect the final day that was reviewed for claims prior to the printing of the notice. This period typically spans an entire 90-day period prior to the printing of the notice. (Note that this is not the same as the processing dates of the first- and last-processed claims on the notice, which may cover a much shorter period.)

The dates are listed with a spelled-out month, numeric day, and complete numeric year (e.g., October 15, 2021) and are separated by an en-dash (not a hyphen); insert spaces to each side of the en-dash. If both the first and last date are within the same calendar year, drop the year from the first date (e.g., October 15 - November 3, 2021). If the dates are in different calendar years, keep the year in both dates (e.g., October 15, 2021 - January 3, 2022).

NOTE: When printing a Pay MSN or other MSN with a single processing date, replace static text "Claims Processed Between" with the label "Claims Processed"; on an MSN of this kind, only the single processing date should be listed, following the formatting conventions described above.

CONTENT

Notice for {Beneficiary Given Name}{Beneficiary Family Name}	
Medicare Number	**{*1EG4-TE5-MK72*}**
Date of This Notice	{**Month DD, YYYY**}
Claims Processed Between	{**Month DD, YYYY**} - {**Month DD, YYYY**}

Or, if the notice is a Pay MSN or an MSN with a single processing date, use the following:

Notice for {Beneficiary Given Name}{Beneficiary Family Name}	
Medicare Number	**{*1EG4-TE5-MK72*}**
Date of This Notice	{**Month DD, YYYY**}
Claims Processed	{**Month DD, YYYY**}

E. Deductible Status

This subsection contains information on the beneficiary's progress towards meeting his or her deductible(s).

GLOBAL SPECIFICATIONS

Position

The starting position of this subsection is fixed, although its length is variable. The content area begins (0″, 4.51″), 19 points from the baseline of the Notice Details subsection. It is one-column or 259 points in width, and its height is dependent on dynamic content.

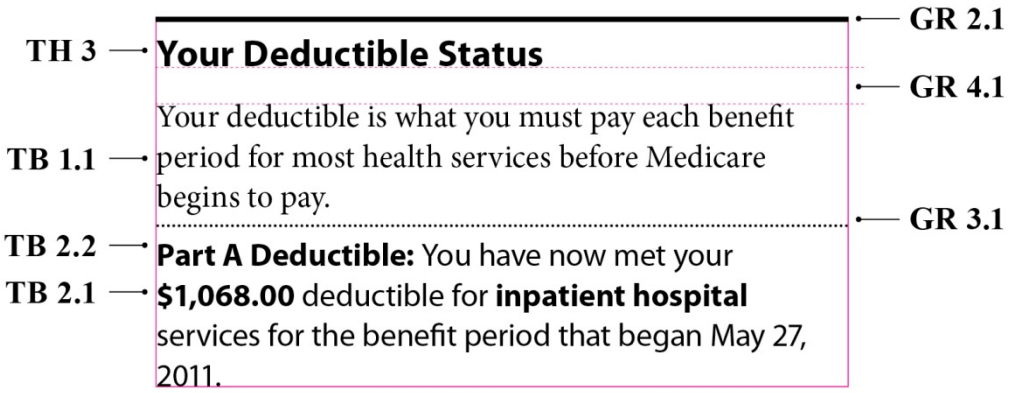

figure 10.3.3.E

FORMATTING
[GR 2.1] black rule
[TH 3] subsection header
[GR 4.1] space after header
[TB 1.1] generic descriptive body text
[GR 3.1] dotted rule
[TB 2.2] deductible header [TB 2.1] beneficiary-specific body text
[TB 2.2] dynamic elements within beneficiary-specific text

PART A INPATIENT, HOSPICE, AND HOME HEALTH (A) SPECIFICATIONS

DYNAMIC RULES

Possible Variations

For Part A claims, content in the beneficiary-specific portion of this subsection is subject to the following variations:

At least one claim is for Part A Inpatient services that do carry a deductible and (e.g., inpatient hospital care) relate to a single benefit period, and

- The beneficiary has paid nothing or has paid a portion of his or her deductible, but has not yet met it in full for the benefit period; or
- The beneficiary has met his or her deductible in full for the benefit period.

or

- At least two claims are for Part A Inpatient services that do carry a deductible and relate to multiple benefit periods, and
- The beneficiary has paid nothing or has paid a portion of his or her deductible, but has not yet met it in full for all benefit periods; or
- The beneficiary has met his or her deductible in full for all benefit periods; or
- The beneficiary has a mixture of met and unmet deductibles for the benefit periods related to claims on the notice.

or

- Claims are for Part A services, but not for any services with a Part A deductible (e.g., Skilled Nursing Facility, home-health, or hospice care).

See Exhibit 2.3 for example scenarios for Part A Inpatient and combined Part A Inpatient and 'B of A'.

Single Benefit Periods

Only one active benefit period related to the claims listed on the statement should be printed. If there are any additional claims that pertain to another benefit period, suppress the status.

Variable and Dynamic Content

If the notice does contain at least one inpatient claim, one or some combination of the following statements should be printed:

> You have now met **${#,###.##}** of your **${#,###.##}** deductible for **inpatient hospital** services for the benefit period that began on {**Month DD, YYYY**}.
>
> or
>
> You have now met your **${#,###.##}** deductible for **inpatient hospital** services for the benefit period that began on {**Month DD, YYYY**}.

Or, if all the notice's claims do not carry a deductible - as for Skilled Nursing Facility, home-health, and hospice claims - the beneficiary-specific portion of this subsection should contain the following statement:

> You did not have inpatient hospital claims this claim period, so you did not have to pay towards the Part A deductible.

Or, if all the notice's claims are rejected, and there is no deductible information, the beneficiary-specific portion of this subsection should contain the following statement:

> You did not have any payable claims this claim period, so you did not have to pay towards the Part A deductible.

Beneficiary-specific content should be used to populate the dynamic fields noted above. In the phrase "You have now met **${#,###.##}** of your **${#,###.##}** deductible", the first dynamic figure should indicate the amount the beneficiary had paid toward his or her deductible for the associated benefit period, as of the date the MSN was printed.

The second dynamic figure should indicate the total amount of the deductible, as specified by CMS, for the related benefit period. (In the second variation, where the beneficiary has met his or her deductible in full, only the total deductible amount needs to be indicated.)

Note that the amount should be rounded to the nearest whole dollar. Insert a comma between the thousands' digit and the hundreds' digit of any four-figure amount. If the beneficiary has not paid any amount toward his or her deductible, use **$0.00** for zero (e.g., You have now met **$0.00** of your **$1,068.00** deductible.).

The dynamic date should reflect the start date of the inpatient hospital benefit period associated with the claim.

CONTENT

Language for the Part A Inpatient deductible subsection is as follows:

Your Deductible Status

Your deductible is what you must pay each benefit period for most health services before Medicare begins to pay.

Part A Deductible: You have now met **${#,###.##}** of your **${#,###.##}** deductible for **inpatient hospital** services for the benefit period that began on {**Month DD, YYYY**}.

or, if the claim is without a deductible use:

Your Deductible Status

Your deductible is what you must pay each benefit period for most health services before Medicare begins to pay.

Part A Deductible: You did not have inpatient hospital claims this claim period, so you did not have to pay towards the Part A deductible.

or, if the claim is without a deductible information due to rejected claims:

Your Deductible Status

Your deductible is what you must pay each benefit period for most health services before Medicare begins to pay.

Part A Deductible: You did not have any payable claims this claim period, so you did not have to pay towards the Part A deductible.

PART B (ASSIGNED AND UNASSIGNED) AND ‘B OF A’ SPECIFICATIONS

DYNAMIC RULES

Possible Variations

For MSNs with claims paid by the Part B program - including Home Health (B), DME, and ‘B of A’ claims - the content in the beneficiary-specific portion of this subsection is subject to the following variations:

Claims relate to a single calendar year, and

- The beneficiary has paid nothing or has paid a portion of his or her deductible, but has not yet met it in full for the year; or
- The beneficiary has met his or her deductible in full for the year.

or

- Claims relate to multiple calendar years, and
- The beneficiary has paid nothing or has paid a portion of his or her deductible but has not yet met it in full for all calendar years; or

- The beneficiary has met his or her deductible in full for all calendar years; or

- The beneficiary has a mixture of met and unmet deductibles for the calendar years related to claims on the notice.

See Exhibit 2.2 for examples of different deductible scenarios for Part B MSNs.

Variable and Dynamic Content

There are two basic Part B deductible statements, with up to three dynamic fields:

> You have now met **${###.##}** of your **${###.##}** deductible for {YYYY}.
> or
>
> You have now met your **${###.##}** deductible for {YYYY}.

Beneficiary-specific content should be used to populate the dynamic fields noted above. In the phrase "You have now met {**$###.##**} of your {**$###.##**} deductible", the first dynamic figure should indicate the amount the beneficiary had paid toward his or her deductible for the associated year, as of the date the MSN was printed. The second dynamic figure should indicate the total amount of the deductible, as specified by CMS, for the related year. (In the second variation, where the beneficiary has met his or her deductible in full, only the year needs to be indicated.)

The dynamic date should reflect the calendar year period associated with the claim(s).

Single vs. Multiple Years

If all claims on a notice relate to a single calendar year, the applicable statement above should be printed for that calendar year.

If claims relate to more than one calendar year, use the language above to describe the beneficiary's status for each year for which claims appear on the MSN, up to a maximum of three. If there are more than three benefit years referenced by the claims on the MSN, list the deductible status of the three most recent years.

CONTENT

Language for the Part B deductible subsection is as follows:

> **Your Deductible Status**
>
> Your deductible is what you must pay for most health services before Medicare begins to pay.
>
> **Part B Deductible:** You have now met your **${###.##}** deductible for {YYYY}.
>
> or
>
> **Your Deductible Status**
>
> Your deductible is what you must pay for most health services before Medicare begins to pay.
>
> **Part B Deductible:** You have now met **${###.##}** of your **${###.##}** deductible for {YYYY}.
>
> or
> **Your Deductible Status**

Your deductible is what you must pay for most health services before Medicare begins to pay.

Part B Deductible: You have now met your **${###.##}** deductible for {YYYY}. You have now met **${###.##}** of your **${###.##}** deductible for {YYYY}.

or

Your Deductible Status

Your deductible is what you must pay for most health services before Medicare begins to pay.

Part B Deductible: You have now met your **${###.##}** deductible for {YYYY}. You have now met your **${###.##}** deductible for {YYYY}. You have now met **${###.##}** of your **${###.##}** deductible for {YYYY}.

DME (ASSIGNED AND UNASSIGNED) SPECIFICATIONS

DYNAMIC RULES

Possible Variations

For MSNs with claims paid by the Part B program - including Home Health (B), DME, and 'B of A' claims - the content in the beneficiary-specific portion of this subsection is subject to the following variations:

Claims relate to a single calendar year, and

- The beneficiary has paid nothing or has paid a portion of his or her deductible, but has not yet met it in full for the year; or
- The beneficiary has met his or her deductible in full for the year.

or

- Claims relate to multiple calendar years, and
- The beneficiary has paid nothing or has paid a portion of his or her deductible but has not yet met it in full for all calendar years; or
- The beneficiary has met his or her deductible in full for all calendar years; or
- The beneficiary has a mixture of met and unmet deductibles for the calendar years related to claims on the notice.

or

- The claim listed is denied for being a duplicate, and
- The beneficiary deductible status is not available to list because the claims data does not go to CWF.

See Exhibit 2.2 for examples of different deductible scenarios for Part B MSNs.

Variable and Dynamic Content

There are two basic Part B deductible statements, with up to three dynamic fields:

> You have now met **${###.##}** of your **${###.##}** deductible for {YYYY}.
>
> or
>
> You have now met your **${###.##}** deductible for {YYYY}.
>
> Or
>
> You did not have any payable claims this claim period, so you did not have to pay towards the Part B deductible.

Beneficiary-specific content should be used to populate the dynamic fields noted above. In the phrase "You have now met {**$###.##**} of your {**$###.##**} deductible", the first dynamic figure should indicate the amount the beneficiary had paid toward his or her deductible for the associated year, as of the date the MSN was printed. The second dynamic figure should indicate the total amount of the deductible, as specified by CMS, for the related year. (In the second variation, where the beneficiary has met his or her deductible in full, only the year needs to be indicated.)

The dynamic date should reflect the calendar year period associated with the claim(s).

Single vs. Multiple Years

If all claims on a notice relate to a single calendar year, the applicable statement above should be printed for that calendar year.

If claims relate to more than one calendar year, use the language above to describe the beneficiary's status for each year for which claims appear on the MSN, up to a maximum of three. If there are more than three benefit years referenced by the claims on the MSN, list the deductible status of the three most recent years.

CONTENT
Language for the Part B deductible subsection is as follows:

> **Your Deductible Status**
>
> Your deductible is what you must pay for most health services before Medicare begins to pay.
> **Part B Deductible:** You have now met your **${###.##}** deductible for {YYYY}.
>
> or
>
> **Your Deductible Status**
>
> Your deductible is what you must pay for most health services before Medicare begins to pay.
> **Part B Deductible:** You have now met **${###.##}** of your **${###.##}** deductible for {YYYY}.
>
> or
>
> **Your Deductible Status**
>
> Your deductible is what you must pay for most health services before Medicare begins to pay.

Part B Deductible: You have now met your **${###.##}** deductible for {YYYY}. You have now met **${###.##}** of your **${###.##}** deductible for {YYYY}.

or

Your Deductible Status

Your deductible is what you must pay for most health services before Medicare begins to pay.

Part B Deductible: You have now met your **${###.##}** deductible for {YYYY}. You have now met your **${###.##}** deductible for {YYYY}. You have now met **${###.##}** of your **${###.##}** deductible for {YYYY}.

Or, if the claim is without a deductible use:

Your Deductible Status

Your deductible is what you must pay for most health services before Medicare begins to pay.
Part A Deductible: You did not have any payable claims this claim period, so you did not have to pay towards the Part B deductible.

COMBINED PART A INPATIENT AND 'B OF A' SPECIFICATIONS

DYNAMIC RULES

When an MSN contains both Part A and Part B claims, then the deductible status for both types of claims must be listed. Follow the rules above for generating the beneficiary-specific content. Following the generic introduction, place the Part A deductible information, then the Part B deductible information.

CONTENT

Sample content for a combined deductible section:

Your Deductible Status

Your deductible is what you must pay each benefit period for most health services before Medicare begins to pay.
Part A Deductible: You have now met **${#,###.##}** of your **${#,###.##}** deductible for inpatient hospital services for the benefit period that began on {**Month DD, YYYY**}.

Part B Deductible: You have now met your **${###.##}** deductible for {YYYY} and **${###.##}** deductible for {YYYY}. You have now met **${###.##}** of your **${###.##}** deductible for {YYYY}.

F. Be Informed

This subsection contains changeable messaging from CMS.

POSITION

The position of this subsection is dynamic. The content area follows the Deductible Status subsection with 19 points from the baseline of the last line of the Deductible Status subsection. It is one-column wide with a variable length depending on the body text.

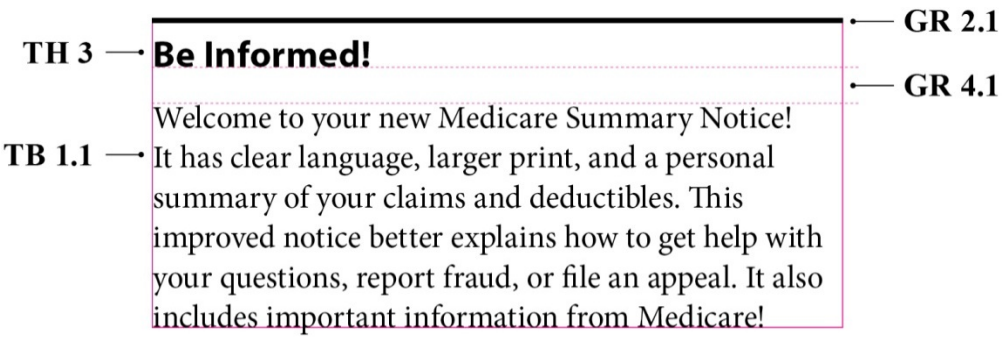

figure 10.3.3.F

FORMATTING
[GR 2.1] black rule
[TH 3] subsection header
[GR 4.1] space after header
[TB 1.1] body text

DYNAMIC RULES

This subsection can accommodate one message from CMS of up to 300 characters (inclusive of spaces).

The current message for this subsection, also previously known as Be Informed, can be found on the CMS website: http://www.cms.gov/Medicare/Medicare-General-Information/MSN/index.html?redirect=/MSN/02_MSNMessages.asp

CONTENT

Be Informed!
{CMS message of up to 300 characters]

G. Status Notification

This subsection contains high-priority messages to beneficiaries about the nature and status of the notice.

POSITION

This subsection contains text content of a variable size.
The content area begins (3.9″, 1.54″), is one-column or 259 points in width with variable height, and has from one to two lines of text.

[The below figures have been revised.]

figure 10.3.3.G1

figure 10.3.3.G2

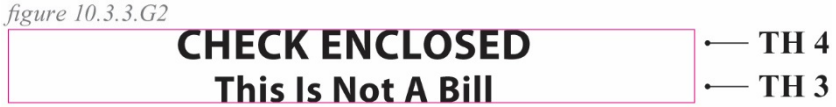

figure 10.3.3.G3

figure 10.3.3.G4

FORMATTING

[TH 4] Big Header, all caps, center aligned
[TH 3] Small Header, center aligned

DYNAMIC RULES
The content of this section is variable depending on whether the notice is original or a duplicate copy of a previously generated notice or a Pay MSN.

If the notice is an original MSN, then the notification header indicates that the notice is not a bill.

If the notice is a duplicate, then the notification header indicates that the notice is a duplicate copy, and the subtitle indicates that the notice is not a bill. For an example of a duplicate MSN, see Exhibit 2.1.

If the notice is a Pay MSN, then the notification header indicates that the notice has a check enclosed, and the subtitle indicates that the notice is not a bill. For examples of Pay MSNs, see the Exhibits section.
CONTENT

THIS IS NOT A BILL

or

DUPLICATE COPY
This Is Not a Bill

or

CHECK ENCLOSED
This Is Not a Bill
or

CHECK SENT SEPARATELY
This Is Not a Bill

H. Claims & Costs

This subsection contains a summary of the approval status of the claims on the notice and the beneficiary's total liability for those claims. This subsection has two states: approved and denied. For examples of the Claims & Cost chart, reference any of Exhibits 1.1 through 1.9, showing the extended family of MSNs.

POSITION

The starting position of this subsection is fixed, although its length is variable.

The content area begins (3.9″, 2.75″). This subsection should top-align with the Notice Details subsection on the left column. It is one-column or 259 points in width and has a variable height dependent on dynamic content.

The "approved" version has five lines. The "denied" version has seven lines. Questions in bold have corresponding answers that are right aligned. Questions and static text field have a maximum of 27 characters, and the answer fields have a maximum of four characters. The total line, in a gray field, is to have a maximum of 12 characters for the total dollar amount.

figure 10.3.3.H1

FORMATTING - APPROVED
[GR 2.1] black rule
[TH 3] subsection header
[GR 4.1] space after header
[TB 2.2] approval question [TB 2.2] “Yes”, all caps, right aligned
[GR 5] space after text
[TB 1.1] note text under approval
[GR 3.1] dotted rule
[GR 1] gray fill
[TB 2.2] total header [TB 2.2] Total amount, right aligned

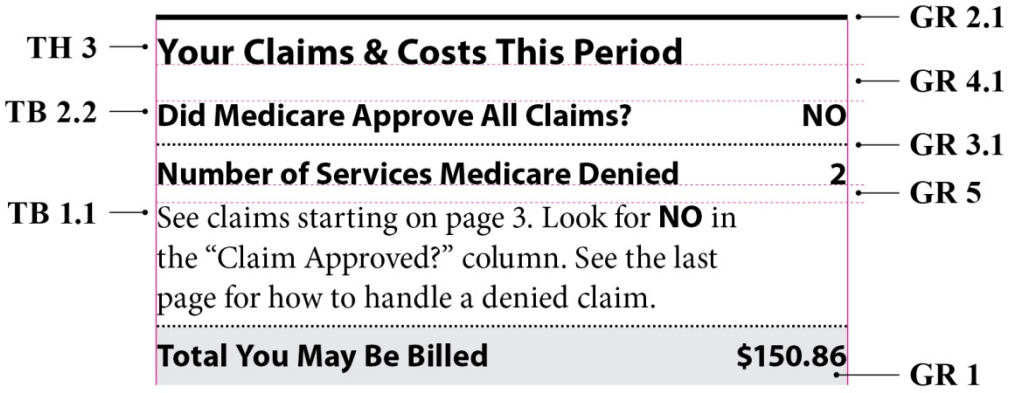

figure 10.3.3.H2

FORMATTING - DENIED
[GR 2.1] black rule
[TH 3] subsection header
[GR 4.1] space after header
[TB 2.2] approval question [TB 2.2] “No”, bold, all caps, right aligned
[GR 3.1] dotted rule
[TB 2.2] number denied [TB 2.2] right aligned
[TB 1.1] note text under approval
[GR 3.1] dotted rule
[GR 1] gray fill
[TB 2.2] total header [TB 2.2] Total amount, right aligned

DYNAMIC RULES

This subsection contains up to three dynamically generated units of content:

Items approved or denied

The first content unit relates to whether all the claim items on the notice were approved. If yes, then the first two-line language option below should be printed, with a dynamically generated “YES” in all capital letters. If not, then the second, three-line language option should be included, with a dynamically generated “NO” in bold, all capital letters, plus a line totaling the number of denied claim items on the notice. (Note that this

should correspond to a count of all the line items in the Claims section with NO in the "Service Approved?" column.)

Total MSN liability

The second content unit provides a dollar figure of the total amount of the beneficiary's liability for the claims on the notice. This should correspond to a sum of all the "Maximum You May Be Billed" claim totals on the notice.

Note that the amount should not be rounded - it should include any cents. Insert a comma between the thousands' digit and the hundreds' digit of any four-figure or greater amount. If the beneficiary does not have any financial liability for the claims on the MSN, use **$0.00** for zero.

PART A INPATIENT SPECIFICATIONS

CONTENT

Your Claims & Costs This Period
Did Medicare Approve All Claims? {**YES}**
See page 2 for how to double-check this notice

or

Did Medicare Approve All Claims? {**NO**}
Number of Claims Medicare Denied {**# of claims denied**}

See claims starting on page 3. Look for **NO** in the "Claim Approved?" column. See the last page for how to handle a denied claim.

Total You May Be Billed **$**{**###,###.##**}

'B OF A',, HOSPICE, HOME HEALTH AND PART B (ASSIGNED AND UNASSIGNED) SPECIFICATIONS

CONTENT

Your Claims & Costs This Period
Did Medicare Approve All Services? {**YES}**
See page 2 for how to double-check this notice

or

Did Medicare Approve All Services? {**NO**}
Number of Services Medicare Denied {**# of services denied**}
See claims starting on page 3. Look for **NO** in the "Service Approved?" column. See the last page for how to handle a denied claim.

Total You May Be Billed **$**{**###,###.##**}

DME (ASSIGNED AND UNASSIGNED) Specifications

CONTENT

Your Claims & Costs This Period
Did Medicare Approve All Items and Services? {**YES}**

See page 2 for how to double-check this notice

or

Did Medicare Approve All Items and Services? {**NO**}
Number of Items or Services Medicare Denied {**# of services denied**}
See claims starting on page 3. Look for **NO** in the "Item/Service Approved?" column. See the last page for how to handle a denied claim.

Total You May Be Billed **$**{**###,###.##**}

COMBINED MSN: PART 1 INPATIENT, HOSPICE, HOME HEALTH OR 'B OF A', SPECIFICATIONS

CONTENT

Your Claims & Costs This Period
Did Medicare Approve All Claims and Services? {**YES}**
See page 2 for how to double-check this notice

or

Did Medicare Approve All Claims and Services? {**NO**}
Number of Claims and Services Medicare Denied {**# of services denied**}
See claims starting on page 3. Look for **NO** in the "Approved?" column. See the last page for how to handle a denied claim.

Total You May Be Billed **$**{**###,###.##**}

I. Facility/Provider/Supplier List
This subsection contains a dynamically generated summary of the providers/suppliers/facilities that submitted claims on the notice.

Up to six providers/suppliers/facilities may be listed here; each unique provider/supplier/facility should only be listed once, even if they submitted multiple claims. See Exhibit 2.4 for an example of a list that contains the maximum six providers/suppliers/facilities.

GLOBAL SPECIFICATIONS

POSITION

The position of this subsection is dynamic. The content area follows the Claims & Costs subsection on the right column with 19 points from the baseline. It is one-column or 259 points in width with a variable length, depending on the number of providers listed. The heading of the subsection is also dynamic, depending upon the member of the MSN family.

The facility/provider/supplier name has a maximum of 40 characters. The date and name of the provider/supplier/facility should be contained on one line each.

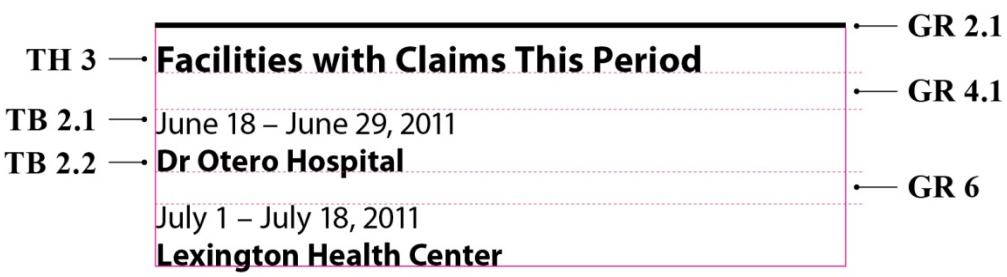

figure 10.3.3.I

FORMATTING
[GR 2.1] black rule
[TH 3] subsection header
[GR 4.1] space after header
[TB 2.1] date
[TB 2.2] provider/facility/supplier name
[GR 6] space between paragraphs
[TB 2.1] date
[TB 2.2] provider/facility/supplier name
[GR 6] space between paragraphs
[TB 2.1] date
[TB 2.2] provider/facility/supplier name

(if more than 6 providers)
[GR 3.1] dotted rule
[TB 1.1] provider continuation note

DYNAMIC RULES

Providers should be listed in chronological order, by first date of service. The date is listed with a spelled-out month, numeric day, and complete numeric year (e.g., October 15, 2021).

If a provider has multiple claims and/or multiple dates of service, list the first and last date of service for that provider, separated by an en-dash; insert spaces to either side of the en-dash. If both the first and last dates are within the same calendar year, drop the year from the first date (e.g., October 15 - November 3, 2021). If the dates are in different calendar years, keep the year in both dates (e.g., October 15, 2021 - January 3, 2022).

In case of Part B, when there is more than one provider on a single claim, list the name of the first provider filing the claim.

In the event that the notice includes more than six unique providers, stop printing the list after the sixth chronological unique provider and insert the "You have more…" note listed in the Content specifications below.

PART A INPATIENT AND 'B OF A', SPECIFICATIONS

CONTENT

Facilities with Claims This Period
{Month DD, YYYY}

or

{Month DD} - {Month DD, YYYY}
or

{Month DD, YYYY} - {Month DD, YYYY}
{Facility Name}
[repeat, up to six unique facilities; if more than six exist, insert:]
You visited more facilities this period. Go to your complete list of claims, starting on page 3.

PART B (ASSIGNED AND UNASSIGNED), HOSPICE, AND HOME HEALTH (A) AND (B) SPECIFICATIONS

CONTENT

Providers with Claims This Period
{Month DD, YYYY}

or
{Month DD} - {Month DD, YYYY}

or

{Month DD, YYYY} - {Month DD, YYYY}
{Provider Name}

[repeat, up to six unique providers; if more than six exist, insert:]
You saw more providers this period. Go to your complete list of claims, starting on page 3.

DME (ASSIGNED AND UNASSIGNED) SPECIFICATIONS

CONTENT

Suppliers with Claims This Period
{Month DD, YYYY}

or

{Month DD} - {Month DD, YYYY}

or

{Month DD, YYYY} - {Month DD, YYYY}
{Supplier Name}
[repeat, up to six unique suppliers; if more than six exist, insert:]
You bought from more suppliers this period. Go to your complete list of claims, starting on page 3.

COMBINED MSN: PART A INPATIENT, HOSPICE OR HOME HEALTH SPECIFICATIONS

CONTENT

Facilities and Providers with Claims This Period
{Month DD, YYYY}

or

{Month DD} - {Month DD, YYYY}
or

{Month DD, YYYY} - {Month DD, YYYY}
{Facility or Provider Name}
[repeat, up to five unique facilities; if more than five exist, insert:]
You visited more facilities this period. Go to your complete list of claims, starting on page 3.

J. Foreign Language Footer

This subsection contains a flash image with instructions for Spanish and Mandarin speakers.

POSITION

This subsection contains information of a fixed size. It does not vary in overall width or length. It begins (0″, 9.7″), and it is full-page or 540 points in width and 27 points in height.

NOTE: The image area will go beyond the 0.5 inch bottom margin of the page. This is an exception just for the first page, and all pages to follow should follow the standard margin.

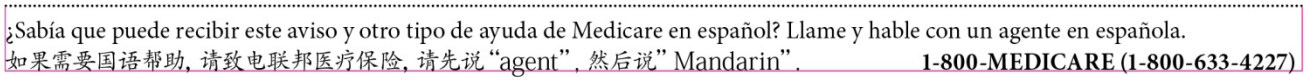

figure 10.3.3.J

FORMATTING
[GL 2] foreign-language footer

DYNAMIC RULES
n/a
CONTENT
n/a

20.1 - Specifications for Content Variations of Spanish MSNs

(Rev.4286, Issued: 04-26-19, Effective: 05-28-19, Implementation: 05-28-19)

A. Language & Style Conventions (Global)

Spanish text does not follow the convention of title case. All headers should follow sentence case, where the first letter of the header (and proper names, such as “Medicare”) is capitalized, but all remaining text is lowercase.

Spanish dates with be listed with numeric day, spelled-out month, and complete numeric year with ‘de’ in between the fields (e.g., 16 de septiembre de 2011).

B. Notice Title (10.3.3:A)

The notice descriptive tagline on Spanish MSNs run in two lines.

[The below figure is new.]

figure 20.1.B

C. Notice Details (10.3.3:D)

The gray highlight box on Spanish MSNs the same width and 137 points height. This will account for the length of the date being longer in Spanish.

figure 20.1.C

D. Be Informed (10.3.3:F)

This subsection can accommodate one message from CMS of up to 375 characters (inclusive of spaces) in Spanish.

E. Foreign Language Footer (10.3.3:J)

The Foreign Language Footer flash image on page 1 is not needed on Spanish MSNs and should be suppressed.

F. How to Report Fraud (10.3.5:C)

The third and final paragraph of this section contains a fraud-specific message from CMS. The message must be a maximum of 225 characters long (inclusive of spaces).

G. Your Messages from Medicare (10.3.5:G)

This subsection can accommodate up to four messages from CMS. First and second message fields must accommodate messages with a maximum of 200 characters each (inclusive of spaces) and third and fourth message fields must accommodate messages with a maximum of 250 characters each (inclusive of spaces). If there is not sufficient space to print all four messages on page 2, then just the first three messages should be printed.

H. CPT Code Descriptors

Spanish A/B MSNs shall use the HCPCS (level 1)/CPT consumer-friendly code descriptors. The service description has a maximum of 300 characters. Suppress the rest if the description runs longer.

Spanish DME MSNs shall use the HCPCS level 2 short 28-character code descriptors.

I. Claim Column Titles (10.3.6:D)

The claim column titles runs in 4 lines in the Spanish MSNs. The height is 50 points but the widths of columns stay the same. Content variation and formatting stays the same as English.

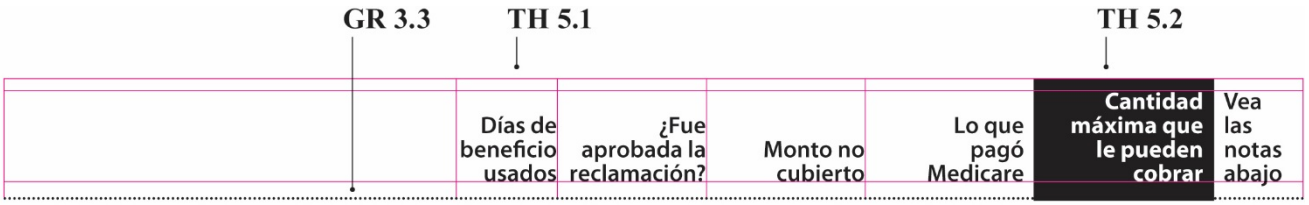

figure 20.1.II

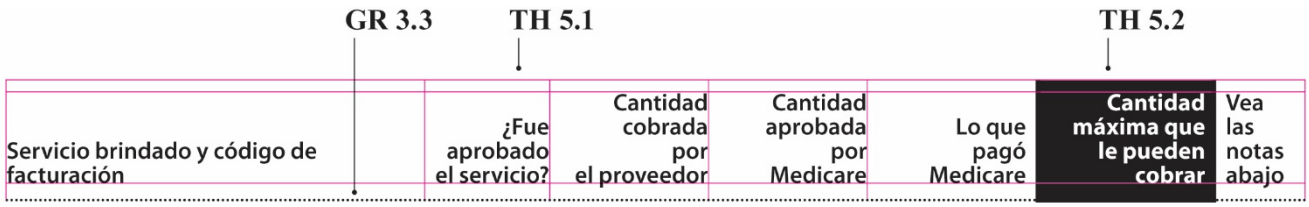

figure 20.1.I2

J. Get More Details (10.3.8:B)

Due to restriction on space, the content area for this subsection begins (0″, 0.97″) or 8 points from the baseline of the “Section Title” subsection.

K. If You Need Help Filing Your Appeal (10.3.8:D)

See Exhibit 3.17 for alternate language for contact when the MSN mailing address is outside the 50 states.

L. Find Out More (10.3.8:E)

Due to space restraints, the Spanish MSNs do not have a header for “Find Out More About Appeals” subsection. Instead only the body content is listed as the last paragraph of the previous subsection, “If You Need Help Filing Your Appeal” (10.3.8.D).

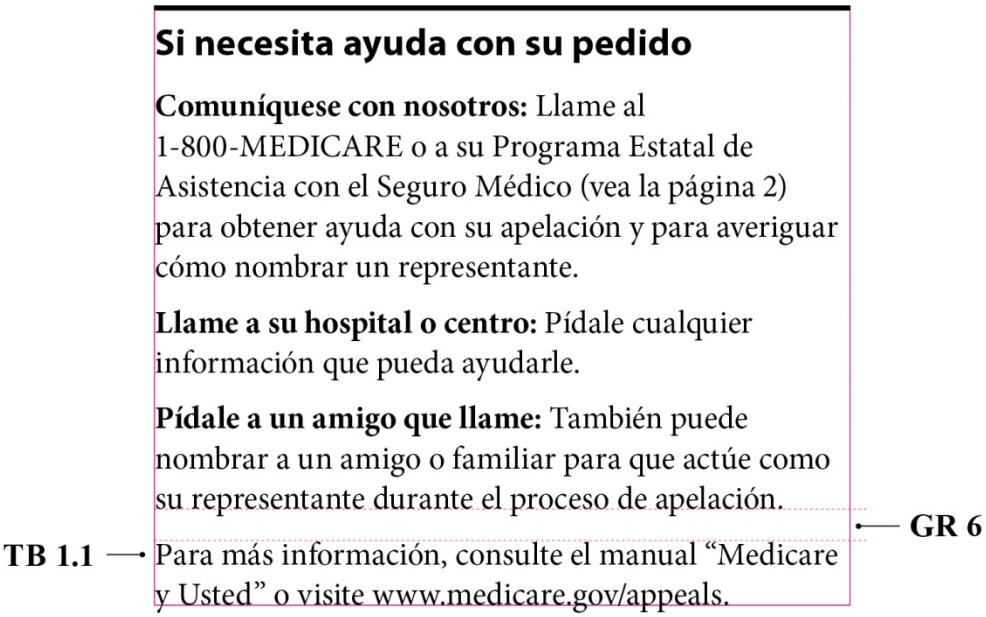

figure 20.1.K

M. File an Appeal in Writing (10.3.8:F)

Due to restriction on space, the content area for this subsection begins (0″, 0.97″). This should top align with the “Get More Details” subsection in the left column.

If the contractor needs 5 lines for the mailing address, delete GR 4.1 space between step 7 and the MAC address to fit the gray box within the page.


documentación para su archivo personal.

7 Envíe este aviso y toda la documentación necesaria a la siguiente dirección:
Medicare Claims Office
c/o First Coast Service Options, Inc.
attn: Appeals Department
Street Address
City, ST 12345-6789

figure 20.1.M

FORMATTING

[GR 1] gray fill

[TH 3] subsection header

[GR 4.1] space after header

[TB 2.1] body text

[GR 4.1] space after header

[TB 2.2] step 1 [TB 2.1] body text

[GR 4.1] space after header

[TB 2.2] step 2 [TB 2.1] body text

[GR 4.1] space after header

[TB 2.2] step 3 [TB 2.1] body text

[GR 4.1] space after header

[TB 2.1] fill in category

[GR 5] space after text

[GR 7] fill in box

[GR 6] space after text

[TB 2.1] fill in category

[GR 5] space after text

[GL 7] fill in box

[GR 4.1] space after header

[TB 2.2] steps 4 - 7 [TB 2.1] body text

[TB 2.2] MAC address

N. Spanish RRB S MAC MSNs (10.3.12)

The Spanish RRB Part B MSNs follow the same content and specifications variations in this section. See Exhibit 3.9 for translations specific to RRB Part B MSNs.