CMS Manual System

Pub. 100-01 Medicare General Information, Eligibility, and Entitlement

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 12 **Date: October 22, 2004**

CHANGE REQUEST 3416

SUBJECT: New Policy and Refinements on Billing Noncovered Charges to Fiscal Intermediaries (FIs)

I. SUMMARY OF CHANGES: Basic comprehensive instructions on billing noncovered charges to FIs are found in Chapter 1, Section 60 of Medicare's On-line Publication 100-04 on Claims Processing. Since publication of the summary instructions, CMS has become aware of a few required refinements and new needs: (1) Allowing totally noncovered provider-liable outpatient claims without either condition codes 20 or 21, (2) providing additional guidance on billing bundled services related to an ABN, with specific examples for rural health clinics (RHCs), federally qualified health clinics (FQHCs) and laboratory panel tests billed on institutional claims, (3) Bypassing of some edits related to noncovered ambulance line items using the –QM or –QN modifiers , and (4) Other updates to Web site addresses, conforming text and comparable administrative changes. The attached revision for this publication provides a needed link to 100-04 to clarify existing language on liability for collection of co-insurance and deductible.

NEW/REVISED MATERIAL - EFFECTIVE DATE*: April 1, 2005 for timely claims received on or after that date, or ambulance claims suspended as of that date with FISS reason code 31322, with dates of services on or after October 1, 2000.

IMPLEMENTATION DATE: April 4, 2005

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. 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 not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	3/20.4.1 - Applications of Deductible and Coinsurance in Liability and Indemnification Situations

III. FUNDING: Medicare contractors shall implement these instructions within their current operating budgets.

IV. ATTACHMENTS:

	Business Requirements
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

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

20.4.1 - Applications of Deductible and Coinsurance in Liability and Indemnification Situations

(Rev.12, Issued: 10-22-04, Effective: 04-01-05, Implementation: 04-04-05)

Under 1879 of the Act, a beneficiary is not responsible for payment of the Part B deductible or coinsurance for items or services that are neither reasonable and necessary to diagnose or treat the illness or injury, nor to improve the functioning of a malformed body member. If the provider knew, or should have known, that Medicare considered such services medically unnecessary, but failed to inform the beneficiary before furnishing them, the provider is held liable for their cost. If the beneficiary made payment for such items or services, he/she can be indemnified for them.

In most cases, however, funds can be collected while awaiting the outcome of review of a demand bill for institutional services-- See Publication 100-04, Chapter 1, §60.3, See §60.3.1 in the same chapter for specific information on limitations on collecting funds from beneficiaries in SNF Part A stays. *In general, see Chapter 30 of that publication for information on limitation of liability.*