CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1928	**Date: March 5, 2010**
	Change Request 6774

Transmittal 1900, dated January 29, 2010, is being rescinded and replaced by Transmittal 1928, dated March 5, 2010 to show the new section as 60.1.1.1 instead of 60.1.1 on the transmittal page and in the manual update. All other material remains the same.

SUBJECT: Correction to Processing of Non-Covered Revenue Codes

I. SUMMARY OF CHANGES: This transmittal revises how Medicare systems process revenue code lines submitted with non-covered charges. It also makes miscellaneous enhancements to the Medicare Claims Processing Manual regarding non-covered charges and Medicare systems.

New / Revised Material
Effective Date: July 1, 2010
[Note: Unless otherwise specified, the effective date is the date of service.

Implementation Date: July 6, 2010

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

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

R/N/D	Chapter / Section / Subsection / Title
R	1/60.1/General Information on Non-covered Charges on Institutional Claims
N	1/60.1.1/Liability Considerations for Bundled Services
R	1/60.5/Coding That Results from Processing Noncovered Charges

III. FUNDING:

SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; Contractor 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 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

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1928	Date: March 5, 2010	Change Request: 6774

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I. GENERAL INFORMATION

A. Background: In October 2004, CMS issued Transmittal 332, Change Request 3416, entitled "New Policy and Refinements on Billing Noncovered Charges to Fiscal Intermediaries (FIs)." This transmittal completed a series of instructions that established requirements for processing non-covered charges on institutional claims and for correctly assigning financial liability for non-covered charges. One underlying premise of those instructions was that any institutional provider should be able submit a claim line with non-covered charges for any service that the provider delivered and that Medicare systems should process that non-covered line to completion without payment. This premise is consistent with the goals of administrative simplification and increasing automated coordination of benefits across various payers.

These instructions contained one significant omission. They failed to take into account the fact that Medicare systems currently determine whether a particular revenue code is valid for Medicare billing without regard to whether the revenue code line is submitted as non-covered. Each fiscal intermediary or Medicare Administrative Contractor that processes institutional claims maintains a revenue code file within the Fiscal Intermediary Shared System (FISS) which lists the revenue codes that are valid for each type of bill. If a provider submits a claim with a revenue code that is not listed on the revenue code file as valid for the submitted type of bill, the claim is returned to the provider. This happens whether the revenue code line is submitted with covered charges or is submitted entirely with non-covered charges.

If a revenue code line is submitted with entirely non-covered charges and no indication that beneficiary liability may apply, these lines should not be returned to the provider. They should be processed to completion without payment, assigning liability to the provider. This transmittal revises Medicare systems to ensure this outcome. The transmittal also contains miscellaneous clarifications to the Medicare Claims Processing Manual.

B. Policy: Claims containing an institutional service line submitted with a revenue code that is not valid for Medicare billing should only be returned to the provider if the line is submitted with covered charges or the claim indicates that beneficiary liability may apply.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)						
		A/B	DME	FI	CA	RH	Shared-System Maintainers	OTHER

		B MAC	E MAC		R RIER	H I	F I SS	M CS	V MS	C WF	
6774.1	Medicare systems shall not return an institutional claim to the provider due to an invalid revenue code if: • the total charges and non-covered charges on the revenue code line are equal, • modifiers -GA, -GL, -GX, -GY, or –TS are not present on the revenue code line, and • Condition code 20 is not present on the claim.						X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B MAC	D ME MAC	F I	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6774.2	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X		X					

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:

X-Ref Requirement Number	Recommendations or other supporting information:
	N/A

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Wil Gehne, wilfried.gehne@cms.hhs.gov, 410-786-6148 or Elizabeth Carmody, elizabeth.carmody@cms.hhs.gov, 410-786-7533.

Post-Implementation Contact(s): Appropriate Regional Office.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers,* use only one of the following statements:

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

Section B: *For Medicare Administrative Contractors (MACs),* include the following statement:

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.

Medicare Claims Processing Manual
Chapter 1 - General Billing Requirements

Table of Contents
(Rev.1928, 03-05-10)

60.1 - General Information on Non-covered Charges on Institutional Claims

(Rev.1928, Issued: 03-05-10, Effective: 07-01-10, Implementation: 07-06-10)

Charges are tied to items or services described by coding on a line of a claim where they appear together. The institutional claim formats (the ANSI ACS X12 837I electronic claim transaction and the Form CMS-1450 [UB-04] paper claim) provide separate fields for the submission of total charges and non-covered charges.

When billing, claims submitters make a choice between submitting charges as covered, or as non-covered. When total charges are submitted and non-covered charges are not submitted, the charges for the claim line are submitted as covered. When a claim line is submitted with covered charges, the provider is seeking payment for that line.

When total charges and non-covered charges submitted on a claim line are equal, the charges for that claim line are submitted as non-covered. When a claim line is submitted with non-covered charges, the provider is not seeking payment for that line and the line is denied payment by Medicare systems. *Therefore, Medicare accepts any National Uniform Billing Committee-approved revenue codes when they are submitted with non-covered charges, without regard to whether these revenue codes would be valid for Medicare billing if submitted seeking payment.*

Lines submitted with covered and non-covered charges can appear together on a single Medicare claim. In rare instances, covered and non-covered charges can appear on the same line. In these cases, the total charge amount is greater than the non-covered charge amount on the line.

Even when Medicare payment is not requested, there can be Medicare notice requirements that establish financial liability between beneficiaries and their providers. These liability notices, such as Advance Beneficiary Notices of Noncoverage (ABNs), serve to ensure that providers can shift the financial liability for items and services to their Medicare patients, consistent with §1862(a)(1) and §1879 of the Social Security Act (i.e., the Act). See Chapter 30 of this manual for more information on financial liability and related notices.

NOTE: In this section, the term ‘provider’ may include institutional providers or suppliers and other comparable entities delivering medical items and services billed on institutional claims.

This statutory ability to shift liability only applies when billing items and services usually covered as part of established Medicare benefits. These benefits are described in law, in Title XVIII of the Act, which authorizes the Medicare Program. Other benefits not addressed in Title XVIII are known as being “statutorily excluded,” meaning Medicare is not authorized to pay for them under the Act.

Financial liability for an item or service that could be a Medicare benefit is codified in statute, along with the benefits themselves. Liability occurs when such items or services are thought to be non-covered by the Program for specific reasons also given in the Act:

- §1862(a)(1) on services that otherwise could be covered but which are not medically reasonable and necessary in the individual case at hand,
- §1862(a)(9) for custodial care which Medicare never covers,
- §1879(g)(1) for home care given to a beneficiary who is neither homebound nor needs intermittent skilled services at home, or lastly, under
- §1879(g)(2) for hospice care given to someone not terminally ill.

When one of these stipulated reasons will apply to a denial on an Original Medicare claim, the reason has to appear on a notice given in advance of delivery of services, and before preparation of a related claim. These notices, like an ABN, give a level of detail that allows the involved beneficiary to understand why no coverage is likely to occur in that specific circumstance.

The financial liability that remains when Medicare does not pay belongs to either providers or beneficiaries. Such determinations are made by Medicare when processing related claims. Sometimes, providers and beneficiaries make their own agreements on payment without billing Medicare, which Medicare allows them to do. More often, Medicare is billed, since resulting denials of claims, even when submitted with non-covered charges, have appeal rights under Medicare over payment. See Chapter 29 of this manual for more information on such appeals.

Appeals rights are not expected to be used for non-covered charges, certainly not with any frequency. When no amounts are in dispute since no payment is sought, appeals tend not to occur. Charges submitted as non-covered should indicate that there is an understanding shared by the involved beneficiary and provider that Medicare payment is not expected. For example, non-covered charges could be used for cosmetic surgery because both parties know this surgery is never a Medicare benefit, or statutorily excluded. The surgery may be billed to Medicare so that subsequent payers could see a Medicare denial when they require proof of denials by payers more primary in the sequence of coverage.

Claims which are rejected by the Medicare contractor or are returned to the provider (or RTP'ed) can be corrected and re-submitted, permitting a payment determination to be made after resubmission. In some cases, beneficiaries may appeal rejections, but they can NEVER appeal RTP'ed claims. Rejections may be apparent on remittances for claims submitted with administrative errors, but beneficiaries cannot be held liable for items and services that were never properly billed to Medicare.

In contrast, denied claims can never be resubmitted, since they are in fact the result of official payment determinations made by Medicare. As mentioned, such determinations can be appealed.

60.1.1.1 – Liability Considerations for Bundled Services

(Rev.1928, Issued: 03-05-10, Effective: 07-01-10, Implementation: 07-06-10)

Some Medicare payment policies group, or bundle, several items or services into a single unit for payment. For example, Medicare has prospective payment systems with established means of

comprehensive payment for a given period of treatment, independent of what particular individual services or items may be delivered in that period. 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 below 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.1928, Issued: 03-05-10, Effective: 07-01-10, Implementation: 07-06-10)

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.

TABLE 4:

Liability	*Remittance Requirement*	*MSN Message*

Beneficiary	*Group code PR for patient responsibility, reason code 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, reason code 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."*

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:*	• *Charges are processed as*

	• *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.*	*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 admission (see IOM Publication 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 Publication 100-05).*	• *Charges are shown as noncovered ;* • *neither utilization nor cost report days are reported.*
No code	*Despite no payment, no code is entered because:*	

entered	• *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.