CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2031	**Date: August 20, 2010**
	Change Request 6874

SUBJECT: Beneficiary-Submitted Claims

I. SUMMARY OF CHANGES: Clarification is being provided on processing claims submitted by Medicare beneficiaries to Carriers and/or A/B MACs. These instructions do not apply to foreign claims or DMEPOS claims.

EFFECTIVE DATE: November 29, 2010
IMPLEMENTATION DATE: November 29, 2010 (NOTE: This CR applies to all claims received on or after the implementation date regardless of the date of service.)

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	1/70.8.8.6/Monitoring Claims Submission Violations
R	1/80.3.2/Handling Incomplete or Invalid Claims

III. FUNDING:

For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractor 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 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: 2031	Date: August 20, 2010	Change Request: 6874

SUBJECT: Beneficiary-Submitted Claims

Effective Date: November 29, 2010

Implementation Date: November 29, 2010
(NOTE: This CR applies to all claims received on or after the implementation date regardless of the date of service.)

I. GENERAL INFORMATION

A. Background: All providers and suppliers are required to enroll in the Medicare program in order to receive payment. In addition, Section 1848 (g)(4)(A) of the Social Security Act requires all providers and suppliers to submit claims for services rendered to Medicare beneficiaries.

B. Policy: Medicare contractors shall:

1) Process beneficiary-submitted claims for services that are not covered by Medicare (e.g., for hearing aids, cosmetic surgery, personal comfort services; see 42 CFR 411.15 for details), in accordance with its normal processing procedures;

2) Process beneficiary-submitted claims for services that are covered by Medicare when the beneficiary has submitted a complete claim (Form CMS-1490S) and all supporting documentation associated with the claim, including an itemized bill with the following information:

- Date of service,
- Place of service,
- Description of illness or injury,
- Description of each surgical or medical service or supply furnished,
- Charge for each service,
- The doctor's or supplier's name and address,
- The provider or supplier's National Provider Identifier (NPI)

Since there is no place on Form CMS-1490S to insert a provider or supplier's NPI, claims submitted by the beneficiary without the provider or supplier's NPI shall not be considered incomplete. The contractor shall use the NPI registry to locate the provider or supplier's NPI. If the contractor determines that the provider or supplier was not a Medicare enrolled provider with a valid NPI, contractors shall follow previously established procedures in order for the claim to be processed and adjudicated through the claims processing system. If an incomplete claim or a claim containing invalid information is submitted, the contractor shall manually return the claim as incomplete with an appropriate letter that specifically communicates all the items listed above which were missing or invalid.

3) Retain the Form CMS-1490S and supporting documentation and return a copy to the beneficiary when manually returning a beneficiary-submitted claim for a Medicare-covered service because the claim is not complete or contains invalid information. In addition the CMS-1490S and supporting documentation shall be maintained for purposes of the timely filing rules in the event that the beneficiary resubmits the claim.

4) Retain Medicare claims records using the following disposition rules.

DISPOSITION:

1. Carriers who Microform Claims

a) Hardcopy Records - Cut off no later than the close of the calendar year (CY) in which paid. The hardcopy claim must be retained in accordance with the following:

(1) If a corresponding master microform has been made and verified, transfer to a Federally-approved records storage facility or hold onsite. Destroy after a total retention of 3 years after the close of the CY in which paid.

(2) If a corresponding master microform record has NOT been made and verified, transfer to a Federally-approved records storage facility or hold onsite. Destroy after a total retention of 6 years and 3 months after the close of the CY in which paid.

b) Microform Records

The master microform record must be retained for a total retention of 6 years and 3 months following the close of the calendar year in which paid.

2. Carriers Who Do Not Microform Claims Records

Cut off at the close of the calendar year (CY) in which paid, then transfer to a Federally-approved records storage facility. Destroy after a total retention of 6 years and 3 months. Earlier cutoff and transfer is authorized. However, the records must be retained for a total retention of 6 years and 3 months following the close of the calendar year in which payment is made.

a) Hardcopy Records - The hardcopy must be retained onsite until the microform has been verified. Cut off at the close of the calendar year in which paid; transfer hardcopy to a Federally-approved records storage facility only if there is a corresponding master microfilm record that can be retained for the period indicated in b. below; otherwise, the hardcopy shall be retained until the 6 years and 3 months period is reached. Earlier cutoff and transfer is authorized. However, the hardcopy must be retained for a total retention of 3 years after the close of the calendar year in which paid.

b) Microform Records - The master microform records must be retained for a total retention of 6 years and 3 months following the close of the calendar year in which payment is made.

When returning a beneficiary-submitted claim, the contractor shall also inform the beneficiary, by letter, that the provider or supplier is required by law to submit a claim on behalf of the beneficiary (for services that would otherwise be payable), and that in order to submit the claim, the provider must enroll in the Medicare program. In addition, contractors should encourage beneficiaries to always seek non-emergency care from a provider or supplier that is enrolled in the Medicare program. If a beneficiary receives services from a provider or supplier that refuses to submit a claim on the beneficiary's behalf (for services that would otherwise be payable by Medicare), and/or refused to enroll in Medicare, the beneficiary should:

1. Notify the contractor in writing that the provider or supplier refused to submit a claim to Medicare, and/or refused to enroll in Medicare, and

2. Submit a complete Form CMS-1490S with all supporting documentation.

The contractor shall process and pay the beneficiary's claim if it is for a service that would be payable by Medicare were it not for the provider or supplier's refusal or inability to submit the claim and/or enroll in Medicare. Claims shall be adjudicated based on whether the service provided is covered or non-covered/excluded rather than on the provider's enrollment status. If for a covered service, the claim shall be processed and the allowed amount reimbursed to the beneficiary, if appropriate. If for a non-covered/excluded service, the claim shall be processed and denied with an appropriate MSN message. This is to include claims submitted for sanctioned/excluded and opt-out providers. For the appropriate MSN message please refer to IOM, Pub. 100-04, Chapter 1, section 70.8.8.6B.

Contractors shall maintain documentation of beneficiary complaints involving violations of the mandatory claims submission policy and a list of the top 50 violators, by State, of the mandatory claim submission policy.

The following instructions, including the NPI requirement, do not apply to foreign claims. The processing of foreign claims shall remain unchanged. The following instructions also do not apply to beneficiary claims submitted to DMEMACs for durable medical equipment, prosthetics, orthotics and supplies. DMEMACs should continue to follow the procedures currently in place.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	**Requirement**	**Responsibility (place an "X" in each applicable column)**									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6874.1	Contractors shall not apply the Business Requirements in this CR to foreign claims or DMEPOS claims.	X			X						
6874.1.1	Contractors shall not apply the NPI requirement when processing foreign and DMEPOS beneficiary claims.	X			X						
6874.2	Contractors shall continue to process foreign and DMEPOS claims per current CMS instructions.	X			X						
6874.3	Contractors shall consider a complete claim to have all items on Form CMS-1490S completed along with an itemized bill with the following information: date of service, place of service, description of illness or injury, description of each surgical or medical service or supply furnished, charge for each service, the doctor's or supplier's name and address, and the provider or supplier's NPI.	X			X						
6874.4	Contractors shall not consider a claim incomplete if the only information missing is the provider or supplier's NPI.	X			X						

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6874.4.1	Contractors shall use the NPI registry to locate the provider or supplier's NPI in order to process and adjudicate the beneficiary-submitted claim.	X			X						
6874.4.2	Contractors shall follow previously established procedures when processing beneficiary-submitted claims when the NPI cannot be located.	X			X						
6874.5	Contractors shall adjudicate claims based on whether the service provided is covered or non-covered/excluded rather than on the provider's enrollment status.	X			X						
6874.5.1	Contractors shall process claims for a covered service and allow the amount reimbursed to the beneficiary, if appropriate. This includes claims submitted for sanctioned/excluded and opt-out providers. If for a non-covered/excluded service, the claim shall be processed and denied with an appropriate MSN message.	X			X						
6874.5.2	Contractors shall use the recommended MSN language for sanctioned/excluded and opt out providers found in the IOM, Pub. 100-04, Chapter 1, section70.8.8.6B.	X			X						
6874.6	If an incomplete claim or a claim containing invalid information is submitted for a Medicare-covered service, contractors shall manually return a copy of the Form CMS-1490S and supporting documentation to the beneficiary with an appropriate letter and retain the originals for their records.	X			X						
6874.6.1	Contractors shall clearly state in the letter which items listed in BR 6874.3 were missing or invalid.	X			X						
6874.6.2	Contractors shall follow the disposition rules outlined above and in the IOM, Pub. 100-04, Chapter 1, section 70.8.8.6B regarding claims record retention.	X			X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6874.7	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 sites 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 the Contractors 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						

IV. SUPPORTING INFORMATION

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

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Alisha Banks, Alisha.Banks@cms.hhs.gov, 410-786-0671

Post-Implementation Contact(s): Alisha Banks, Alisha.Banks@cms.hhs.gov, 410-786-0671

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 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.

70.8.8.6 – Monitoring Claims Submission Violations

(Rev. 2031; Issued: 08-20-10; Effective/Implementation Date: 11-29-10)

A. General

Section 1848(g)(4) of the Social Security Act requires physicians and suppliers to submit claims to Medicare carriers for services furnished on or after September 1, 1990. It also prohibits physicians and suppliers from imposing a charge for completing and submitting a claim. Payment for assigned services not filed within 1 year (for services on or after 9/1/90) are reduced 10 percent. Physicians and suppliers who fail to submit a claim or who impose a charge for completing the claim are subject to sanctions. CMS is responsible for assessing sanctions and monetary penalties for noncompliance.

Physicians and suppliers are not required to take assignment of Medicare benefits unless they are enrolled in the Medicare Participating Physician and Supplier Program or, in the case of physician services, the Medicare beneficiary is also a recipient of State medical assistance (Medicaid) or the service is otherwise subject to mandatory assignment.

B. Compliance Monitoring

To ensure that providers and suppliers are enrolled in the Medicare program and submit claims in compliance with the mandatory claims submission requirements found in §1848(g)(4) of the Social Security Act, contractors shall:

1) Process beneficiary claims submitted to A/B MACs or carriers for services that are not covered by Medicare (e.g., for hearing aids, cosmetic surgery, personal comfort services, etc.; see 42 CFR 411.15 for details), in accordance with its normal processing procedures;

2) Process beneficiary claims submitted to A/B MACs or carriers for services that are covered by Medicare and the beneficiary has submitted a complete and valid claim (Form CMS-1490S) and all supporting documentation associated with the claim, including an itemized bill with the following information*:*

   - *Date of service,*
   - *Place of service,*
   - *Description of illness or injury,*
   - *Description of each surgical or medical service or supply furnished,*
   - *Charge for each service,*
   - *The doctor's or supplier's name and address,*
   - *The provider or supplier's National Provider Identifier (NPI)*

   If the beneficiary furnishes all other information but fails to supply the provider or supplier's NPI the contractor shall not return the claim but rather look up the provider or supplier's NPI using the NPI registry. If the contractor determines that the provider or supplier was not a Medicare enrolled provider with a valid NPI, the contractor shall follow previously established procedures in order to process and adjudicate the claim.

3) *Retain the Form-1490S and supporting documentation and manually r*eturn *a copy to* the beneficiary *if it is* for a Medicare-covered service *and* the claim is *in*complete*,* does not include all required supporting documentation *and/*or contains invalid information. *Contractors shall also include an appropriate letter that specifically communicates all the items listed above which were missing or invalid. In addition, the CMS-1490S and supporting documentation shall be maintained for purposes of the timely filing rules in the event that the beneficiary re-submits the claim.*

If a beneficiary submits a claim on the Form CMS-1500, manually return the Form CMS-1500 claim to the beneficiary, and include a copy of the Form CMS-1490S, along with a letter instructing the beneficiary to complete and return the Form CMS-1490S for processing within the time period prescribed in §70.5, above. Include in the letter a description of missing, invalid or incomplete items required for the Form CMS-1490S that were not included with the submitted Form CMS-1500 or were invalid.

4) Retain Medicare claims records using the following disposition rules.

DISPOSITION:

1. Carriers who Microform Claims

a) Hardcopy Records - Cut off no later than the close of the calendar year (CY) in which paid. The hardcopy claim must be retained in accordance with the following:

(1) If a corresponding master microfilm has been made and verified, transfer to a Federally-approved records storage facility or hold onsite. Destroy after a total retention of 3 years after the close of the CY in which paid.

(2) If a corresponding master microform record has NOT been made and verified, transfer to a Federally-approved records storage facility or hold onsite. Destroy after a total retention of 6 years and 3 months after the close of the CY in which paid.

b) Microform Records

The master microform record must be retained for a total retention of 6 years and 3 months following the close of the calendar year in which paid.

2. Carriers Who Do Not Microfilm Claims Records

Cut off at the close of the calendar year (CY) in which paid, then transfer to a Federally-approved records storage facility. Destroy after a total retention of 6 years and 3 months. Earlier cutoff and transfer is authorized. However, the records must be retained for a total retention of 6 years and 3 months following the close of the calendar year in which payment is made.

a) Hardcopy Records - The hardcopy must be retained onsite until the microform has been verified. Cut off at the close of the calendar year in which paid; transfer hardcopy to a Federally-approved records storage facility only if there is a corresponding master microfilm record that can be retained for the period indicated in b. below; otherwise, the hardcopy shall be retained until the 6 years and 3 months period is reached. Earlier cutoff and transfer is authorized. However, the hardcopy must be retained for a total retention of 3 years after the close of the calendar year in which paid.

b) Microform Records - The master microform records must be retained for a total retention of 6 years and 3 months following the close of the calendar year in which payment is made.

When returning a beneficiary submitted claim, the contractor shall inform the beneficiary that the provider or supplier is required by law to submit a claim on behalf of the beneficiary (for services that would otherwise be payable), and that in order to submit the claim, the provider must enroll in the Medicare program. In addition, contractors shall encourage beneficiaries to always seek non-emergency care from a provider or supplier that is enrolled in the Medicare program.

If a beneficiary receives services from a provider or supplier that refuses to submit a claim to the A/B MAC or carrier, on the beneficiary's behalf, (for services that would otherwise be payable by Medicare), and/or refuses to enroll in the Medicare program, the beneficiary should:

(1) Notify the contractor in writing that the provider or supplier refused to submit a claim to Medicare and/or refused to enroll in Medicare, and

(2) Submit a complete Form CMS-1490S with all supporting documentation.

The contractor shall process and pay the beneficiary's claim if it is for a service that would be payable by Medicare were it not for the provider or supplier's refusal *or inability* to submit the claim and/or enroll in Medicare. *Claims shall be adjudicated based on whether the service provided is covered or non-covered/excluded rather than on the provider's enrollment status. If for a covered service, the claim shall be processed and the allowed amount reimbursed to the beneficiary, if appropriate. If for a non-covered/excluded service, the claim shall be processed and denied with an appropriate MSN message. For sanctioned/excluded and opt-out providers the following MSN messaging is recommended:*

Sanctioned/Excluded provider:

A sanctioned or excluded provider is an individual or business excluded from participation in the Medicare program for a stated period of time as a result of fraudulent activity, program abuse, or impermissible conduct as determined by OIG. CMS will pay the first claim submitted by a beneficiary for the services of a sanctioned/excluded physician or practitioner and immediately notify the sanctioned/excluded physician or practitioner of the exclusion. CMS will not pay a claim for sanctioned/excluded physician or practitioner services more than 15 days after the date on the notice to the physician or practitioner, or after the effective date of the exclusion, whichever is later. Under no circumstance may Medicare payment be made to any entity,

including beneficiaries, for services rendered by such providers after the first claim is paid. An example of language that may be considered:

MSN Message 21.27

English

Services provided by a Medicare sanctioned/excluded provider. No Medicare payment may be made.

Spanish

Los servicios fueron brindado por un proveedor excluído de Medicare, por lo tanto Medicare no pagó por los servicios.

Opt-Out physicians and practitioners:

Medicare payment may be made for the claims submitted by a beneficiary for the services of an opt out physician or practitioner when the physician or practitioner did not privately contract with the beneficiary for services that were not emergency care services or urgent care services and that were furnished no later than 15 days after the date of a notice by the carrier that the physician or practitioner has opted out of Medicare (see 42 C.F.R. 405.435(c)). Therefore, if the beneficiary submits a claim for a service that was furnished by an opt out physician or practitioner, then the carrier must contact the opt out physician or practitioner in order to ascertain whether the beneficiary entered into a private contract with the opt out physician or practitioner. (Note: The carrier should obtain a copy of the private contract from the opt out physician/practitioner before denying the beneficiary's claim if the beneficiary did, in fact, enter into a private contract with the physician or practitioner.) If the beneficiary did not enter into a private contract with the physician or practitioner and the beneficiary did not receive notice from the carrier that the physician opted out of Medicare, then Medicare payment may be made to the beneficiary for the non-emergency and/or non-urgent care services (assuming that the services would otherwise be payable). On the other hand, if the beneficiary did enter into a private contract with the physician or practitioner for the services or received services from the physician/practitioner 15 days after the date of a notice by the carrier that the physician or practitioner has opted out of Medicare, then no Medicare payment may be made. Medicare has instructed opt out physicians and practitioners that private contract language must include beneficiary instruction precluding the beneficiary from billing Medicare for these services. An example of language that may be considered:

MSN Message 21.26

English

Claim denied because services were provided by an Opt-Out physician or practitioner. No Medicare payment may be made.

Spanish

La reclamación fue denegada porque los servicios fueron brindados por un médico ó proveedor que decidió no participar en Medicare, por lo tanto, Medicare no pagó por los servicios.

Contractors shall maintain documentation of beneficiary complaints involving violations of the mandatory claims submission policy and a list of the top 50 violators, by State, of the mandatory claim submission policy.

Contractors are encouraged to educate providers and suppliers that they must be enrolled in the Medicare program before they submit claims for services furnished or supplied to any Medicare beneficiary.

The above policy, including the NPI requirement, is not applicable for foreign beneficiary claims submitted for covered services. These claims should be processed using guidelines for foreign claims.

The above policy, including the NPI requirement, is not applicable to beneficiary claims submitted to DMEMACs for durable medical equipment, prosthetics, orthotics, and supplies. These claims should be processed by DMEMACs using current procedures.

C. Exception When Physician, Other Practitioner, or Supplier Is Excluded From Participating in Medicare Program

Section 1848(g)(4) of the Social Security Act requires physicians, other practitioners, or suppliers to submit claims to Medicare carriers for services furnished after September 1, 1990. This **does not** apply to physicians, other practitioners, or suppliers who have been excluded from participating in the Medicare program. Physicians, other practitioners, and suppliers who have been excluded from the Medicare program are prohibited from submitting claims or causing claims to be submitted. See the Medicare Program Integrity Manual for procedures concerning claims submitted by an excluded practitioner, his/her employer, or a beneficiary for services or items provided by an excluded physician, other practitioner, or supplier. Carriers must maintain the systems capability to identify claims submitted by excluded physicians, other practitioners, or suppliers as well as items or services provided, ordered, prescribed, or referred by an excluded party.

When an excluded physician, other practitioner, or supplier has not submitted a claim on behalf of the beneficiary and/or the beneficiary has submitted the claim themselves, do **not** send a notification letter to the physician, other practitioner, or supplier warning of civil monetary penalties due to noncompliance with §1848(g)(4)(A) of the Act. Instead, follow the instructions in the Program Integrity Manual.

80.3.2 - Handling Incomplete or Invalid Claims

(Rev. 2031; Issued: 08-20-10; Effective/Implementation Date: 11-29-10)

Claims processing specifications describe whether a data element is required, not required, or conditional (a data element which is required when certain conditions exist). The status of these data elements will affect whether or not an incomplete or invalid claim (hardcopy or electronic) will be "returned as unprocessable" or “returned to provider” (RTP) by the carrier or FI, respectively. The carrier or FI shall not deny claims and afford appeal rights for incomplete or invalid information as specified in this instruction. (See §80.3.1 for Definitions.)

If a data element is required and it is not accurately entered in the appropriate field, the carrier or FI returns the claim to the provider of service.

- If a data element is required, or is conditional (a data element that is required when certain conditions exist) and the conditions of use apply) and is missing or not accurately entered in its appropriate field, return as unprocessable or RTP the claim to either the supplier or provider of service.

- If a claim must be returned as unprocessable or RTP for incomplete or invalid information, the carrier or FI must, at minimum, notify the provider of service of the following information:

    - Beneficiary’s Name;

    - Claim Number; HIC Number or HICN or Health Insurance Claim Number. This has never been HI Claim Number.

    - Dates of Service (MMDDCCYY) (Eight-digit date format effective as of October 1, 1998);

    - Patient Account or Control Number (only if submitted);

    - Medical Record Number (FIs only, if submitted); and

    - Explanation of Errors (e.g., Remittance Advice Reason and Remark Codes)

NOTE: Some of the information listed above may in fact be the information missing from the claim. If this occurs, the carrier or FI includes what is available.

Depending upon the means of return of a claim, the supplier or provider of service has various options for correcting claims returned as unprocessable or RTP for incomplete or invalid information. They may submit corrections either in writing, on-line, or via telephone when the claim was suspended for development, or submit as a “corrected” claim, or as an entirely new claim if data from the original claim was not retained in the system, as with a front-end return, or if a remittance advice was used to return the claim. The chosen mode of submission, however, must be currently supported and appropriate with the action taken on the claim.

NOTE: The supplier or provider of service must not be denied any services (e.g., modes of submission or customer service), other than a review, to which they would ordinarily have access.

- If a claim or a portion of a claim is "returned as unprocessable" or RTP for incomplete or invalid information, the carrier or FI does not generate an MSN to the beneficiary.

- The notice to the provider or supplier will not contain the usual reconsideration notice, but will show each applicable error code or equivalent message.

- If the carrier or FI uses an electronic or paper remittance advice notice to return an unprocessable claim, or a portion of unprocessable claim:

    1. The remittance advice must demonstrate all applicable error codes. However, there must be a minimum of two codes on the remittance notice (including code MA130).

    2. The returned claim or portion must be stored and annotated, as such, in history, if applicable. If contractors choose to suspend and develop claims, a mechanism must be in place where the carrier or FI can re-activate the claim or portion for final adjudication.

A. Special Considerations

- If a "suspense" system is used for incomplete or invalid claims, the carrier or FI will not deny the claim with appeal rights if corrections are not received within the suspense period, or if corrections are inaccurate. The carrier must return the unprocessable claim through the remittance process, without offering appeal rights, to the provider of service or supplier. The FI uses the RTP process.

  For assigned and unassigned claims submitted by beneficiaries (Form CMS-1490S), that are incomplete or contain invalid information, contractors shall manually return the claims to the beneficiaries. If the beneficiary furnishes all other information but fails to supply the provider or supplier's NPI, and the contractor can determine the NPI using the NPI registry, the contractor shall continue to process and adjudicate the claim. If the contractor determines that the provider or supplier was not a Medicare enrolled provider with a valid NPI, the contractor shall follow previously established procedures in order to process and adjudicate the claim.

  Contractors shall send a letter to the beneficiary with information explaining which information is missing, incorrect or invalid; information explaining the mandatory claims filing requirements; instructions for resubmitting the claim if the provider or supplier refuses to file the claim, or enroll in Medicare, and shall include language encouraging the beneficiary to seek non-emergency care from a provider or supplier that is enrolled in the Medicare program. Contractors shall also notify the provider or supplier about

his/her obligation to submit claims on behalf of Medicare beneficiaries and that providers and suppliers are required to enroll in the Medicare program to receive reimbursement.

Contractors shall consider a complete claim to have all items on the Form CMS-1490S completed along with an itemized bill with the following information*:*

- *Date of service,*
- *Place of service,*
- *Description of illness or injury,*
- *Description of each surgical or medical service or supply furnished,*
- *Charge for each service,*
- *The doctor's or supplier's name and address,*
- *The provider or supplier's National Provider Identifier (NPI)*

Required information on a claim must be valid for the claim to be considered as complete.

If a beneficiary submits a claim on the Form CMS-1500, return the Form CMS-1500 claim to the beneficiary, and include a copy of the Form CMS-1490S, along with a letter instructing the beneficiary to complete and return the Form CMS-1490S for processing within the time period prescribed in §70.5 above. Include in the letter a description of missing, invalid or incomplete items required for the Form CMS-1490S that were not included with the submitted Form CMS-1500 or were invalid.

NOTE: Telephone inquiries are encouraged.

- The carrier or FI shall not return an unprocessable claim if the appropriate information for both "required" and "conditional" data element requirements other than an NPI when the NPI is effective is missing or inaccurate but can be supplied through internal files. Contractors shall not search their internal files to correct missing or inaccurate "required" and "conditional" data elements required under Sections 80.3.2.1.1 through 80.3.2.1.3 and required for HIPAA compliance for claims governed by HIPAA.

- For either a paper or electronic claim, if all "required" and "conditional" claim level information that applies is complete and entered accurately, but there are both "clean" and "dirty" service line items, then split the claim and process the "clean" service line item(s) to payment and return as unprocessable the "dirty" service line item(s) to the provider of service or supplier**. NOTE:** This requirement applies to carriers only.

No workload count will be granted for the "dirty" service line portion of the claim returned as unprocessable. The "clean" service line portion of the claim may be counted as workload **only if it is processed through the remittance process**. Contractors must abide by the specifications written in the above instruction; return the "dirty" service line portion without offering appeal rights.

- Workload will be counted for claims returned as unprocessable through the remittance process. Under no circumstances should claims returned as unprocessable by means other than the remittance process (e.g., claims returned in the front-end) be reported in the carrier or FI workload reports submitted to CMS. The carrier or FI is also prohibited from moving or changing the action on an edit that will result in an unprocessable claim being returned through the remittance process. If the current action on an edit is to suspend and develop, reject in the front or back-end, or return in the mailroom, the carrier or FI must continue to do so. Workload is only being granted to accommodate those who have edits which currently result in a denial. As a result, workload reports should not deviate significantly from those reports prior to this instruction.

NOTE: Rejected claims are not counted as an appeal on resubmissions.

B. Special Reporting of Unprocessable Claims Rejected through the Remittance Process (Carriers Only):

Carriers must report "claims returned as unprocessable on a remittance advice" on line 15 (Total Claims Processed) and on line 14 (subcategory Non-CWF Claims Denied) of page one of your Form CMS-1565. Although these claims are technically not denials, line 14 is the only suitable place to report them given the other alternatives. In addition, these claims should be reported as processed "not paid other" claims on the appropriate pages (pages 2-9) of CROWD Form T for the reporting month in which the claims were returned as unprocessable through the remittance process. Also, carriers report such claims on Form Y of the Contractor Reporting of Operational and Workload Data (CROWD) system. They report the "number of such claims returned during the month as unprocessable through the remittance process" under Column 1 of Form Y on a line using code "0003" as the identifier.

If a supplier, physician, or other practitioner chooses to provide missing or invalid information for a suspended claim by means of a telephone call or in writing (instead of submitting a new or corrected claim), carriers do not report this activity as a claim processed on Form CMS-1565/1566. Instead, they subtract one claim count from line 3 of Form Y for the month in which this activity occurred.

EXAMPLE: Assume in the month of October 2001 the carrier returned to providers 100 claims as unprocessable on remittance advices. The carrier should have included these 100 claims in lines 14 and 15 of page 1 of your October 2001 Form CMS-1565. During this same month, assume the carrier received new or corrected claims for 80 of the 100 claims returned during the month. These 80 claims should have been counted as claims received in line 4 of your October 2001 Form CMS-1565 page one (and subsequently as processed claims for the reporting month when final determination was made).

Also, during October 2001, in lieu of a corrected claim from providers, assume the carrier received missing information by means of a telephone call or in writing for 5 out of the 100 claims returned during October 2001. This activity should not have been reported as new claims received (or subsequently as claims processed when adjustments are made) on Form CMS-1565. On line 3 of Form Y for October 2001, the carrier should have reported the number 95 (From

claims returned as unprocessable through the remittance process minus 5 claims for which the carrier received missing or invalid information by means of a telephone call or in writing.

For the remaining 15 claims returned during October 2001 with no response from providers in that same month, the carrier should have reported on the Form CMS-1565 or Form Y, as appropriate, any subsequent activity in the reporting month that it occurred. For any of these returned claims submitted as new or corrected claims, the carrier should have reported their number as receipts on line 4 of page one of Form CMS-1565. For any of these returned claims where the supplier or provider of service chose to supply missing or invalid information by means of a telephone call or in writing, the carrier should not have counted them again on Form CMS-1565, but subtracted them from the count of returned claims reported on line 3 of Form Y for the month this activity occurred.

C. Exceptions (Carrier Only)

The following lists some exceptions when a claim may not be "returned as unprocessable" for incomplete or invalid information.

Carriers shall not return a claim as unprocessable:

If a patient, individual, physician, supplier, or authorized person's signature is missing, but the signature is on file, or if the applicable signature requirements have been met, do not return a claim as unprocessable where an authorization is attached to the claim or if the signature field has any of the following statements (unless an appropriate validity edit fails):

Acceptable Statements for Form CMS-1500:

- For items 12, 13, and 31, "Signature on File" statement and/or a computer generated signature;

- For items 12 and 13, Beneficiary's Name "By" Representative's Signature;

For item 12, "X" with a witnessed name and address. (Chapter 26 for instructions.)