CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2474	**Date: MAY 18, 2012**
	Change Request 7629

SUBJECT: Handling Misdirected Claims for Part B Items and Services

I. SUMMARY OF CHANGES: This Change Request (CR) implements new instructions on handling misdirected claims and revises the manual sections for consistency.

EFFECTIVE DATE: July 20, 2012
IMPLEMENTATION DATE: July 20.2012

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	1/10.1.9/Disposition of Misdirected Claims to the B/MAC/Carrier/DME MAC
R	1/10.1.9.1/A Local B/MAC/Carrier Receives a Claims for Services that are in Another Local B/MAC/Carrier"s Payment Jurisdiction
R	1/10.1.9.2/A Local B/MAC/Carrier Receives a Claim for Services that are in A DME MAC"s Payment Jurisdiction
R	1/10.1.9.3/A DME MAC Receives a Claim for Services that are in A Local B/MAC/Carrier"s Payment Jurisdiction
R	1/10.1.9.4/A Local B/MAC/Carrier/DME/MAC Receives a Claim for an RRB Beneficiary
R	1/10.1.9.5/A Local B/MAC/Carrier/DME/MAC Receives a Claim for a UMWA Beneficiary
R	1/10.1.9.6/Medicare Carrier or RRB-Named Carrier to Welfare Carrier
N	1/10.1.9.7/ Protests Concerning Transfer of Requests for Payment to Carrier
N	1/10.1.9.8/Transfer of Claims Material Between Carrier and Intermediary (FI)
N	1/10.1.9.9/A DME MAC receives a Paper Claim with Items or Services that are in Another DME MAC"s Payment Jurisdiction
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: 2474	Date: May 18, 2012	Change Request: 7629

SUBJECT: Handling Misdirected Claims for Part B Items and Services

Effective Date: July 20, 2012

Implementation Date: July 20. 2012

I. GENERAL INFORMATION

A. Background: This Change Request (CR) provides new instructions on handling misdirected claims. Previously, Carriers and Part B Medicare Administrative Contractors (B MAC) were to return assigned claims as unprocessable and deny unassigned claims for Part B items and services if the claims were sent to the wrong carrier/B MAC. Durable Medical Equipment Medicare Administrative Contractors (DME MAC) were to deny paper claims if sent to the wrong DME MAC.

This CR instructs the carriers/B MACs to return all Form CMS-1500 and electronic misdirected claims as unprocessable, regardless of their unassigned/assigned status, including durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) claims that are payable by carriers/B MACs, but billed to the wrong carrier/MAC jurisdiction and misfiled claims for United Mine Workers of America (UMWA) and Railroad Beneficiaries (RRB) beneficiaries. Medicare Summary Notice messages have been removed. This CR also provides new instructions for DMEPOS paper claims that are sent to the wrong DME MAC. Editorial changes are also made to section 10.1.9.

B. Policy: Carriers/B MACs will return as unprocessable Form CMS-1500 and electronic claims for Part B items and services, regardless of their assigned or unassigned status, if submitted to the wrong Carrier/B MAC. DME MACs will return as unprocessable claims submitted on the Form CMS-1500, if submitted to the wrong DME MAC. DME MACs will continue to follow existing procedures for misdirected beneficiary-submitted claims (CMS Form 1490S) and electronic claims that are sent to the wrong DME MAC jurisdiction. Refer to the Internet Only Manual (IOM) Pub 100-04, Chapter 1, Sections 10.1.9 and 80.3.2 for complete instructions on handling misdirected claims. This instruction does not apply to adjustment claims. Contractors should continue to follow existing procedures when the beneficiary has a representative payee on file.

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	
7629.1	Form CMS-1500 or electronic claims, B MACs and carriers shall return as unprocessable claims for items and services furnished outside of their payment jurisdiction.	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	
	Use the following messages for the claims indicated above except for claims that are identified as UMWA and RRB claims: Claim Adjustment Reason Code (CARC) 109 – Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor. Remittance Advice Remark Code (RARC) N104 - This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS Web site at www.cms.gov. RARC MA130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information. **NOTE:** This instruction also applies to claims for DMEPOS items/services that are appropriately billed to the B MAC/carrier, but are billed to the wrong B MAC/carrier payment jurisdiction.										
7629.2	Form CMS-1500 or electronic claims, B MACs and carriers shall return as unprocessable claims for items and services furnished outside of their payment jurisdiction that are in a DME MAC's payment jurisdiction, except for claims that are identified as RRB and UMWA claims, using the messages specified in 7629.1.	X			X						
7629.3	Form CMS-1500 or electronic claims, DME MACs shall return as unprocessable claims for items and services furnished outside of their payment jurisdiction that are in a B MAC/carrier's payment jurisdiction, except claims that are identified as UMWA claims, using the messages specified in 7629.1.		X								
7629.4	Form CMS-1500 or electronic claims, A/B MACs and carriers shall return as unprocessable claims that are identified as RRB claims for Medicare payment that should be processed by the RRB contractor and use the following messages: CARC 109 – Claim not covered by this payer/contractor.	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	
	You must send the claim to the correct payer/contractor. RARC N105 - This is a misdirected claim/service for a RRB beneficiary. Submit paper claims to the RRB carrier: Palmetto GBA, P.O. Box 10066, Augusta, GA 30999. Call 866-749-4301 for RRB EDI information for electronic claims processing. RARC MA130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.										
7629.5	When the RRB receives a claim that is not for an RRB beneficiary, the RRB shall return the claim to the sender and notify them that the claim must be submitted to the local contractor (Part B MAC or carrier) or DME MAC for processing.										RRB
7629.6	Form CMS-1500 or electronic claims, DME MACs shall return as unprocessable claims that are identified as UMWA claims for Medicare payment that should be processed by the UMWA and use the following messages: CARC 109 - Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor. RARC N127 – This is a misdirected claim/service for a United Mine Workers of America (UMWA) beneficiary. Please submit claims to them. RARC MA130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.		X								
7629.7	Form CMS-1500 or electronic claims, A/B MACs and carriers shall return as unprocessable claims that are identified as UMWA claims for Medicare payment that should be processed by the UMWA and use the following messages: CARC 109 - Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.	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	
	RARC N127 – This is a misdirected claim/service for a United Mine Workers of America (UMWA) beneficiary. Please submit claims to them. RARC MA130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.										
7629.8	Form CMS-1500 claims, DME MACs shall return as unprocessable claims that are sent to the wrong DME MAC, using the messages specified in 7629.1. **NOTE:** DME MACs shall continue to follow existing procedures for misdirected beneficiary-submitted claims and electronic claims.		X								
7629.9	Contractors shall be in compliance with the instructions in IOM Pub 100-04, Chapter 1, Sections 10.1.9 and 80.3.2.	X	X		X						

III. PROVIDER EDUCATION 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	
7629.10	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	X	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	
	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.										

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below: N/A
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):
Wendy Knarr, Supplier Claims Processing, by dialing relay service at #711 then have agent call Wendy at 410-786-0843 or email at Wendy.Knarr@cms.hhs.gov and Thomas Dorsey, Practitioner Claims Processing, at 410-786-7434 or Thomas.Dorsey@cms.hhs.gov.

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

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers,* 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.2474, Issued: 05-18-12)

10.1.9 - Disposition of Misdirected Claims to the *B/MAC/*Carrier/DME MAC

(Rev. 2474, Issued: 05-18-12, Effective: 07-20-12, Implementation;-7-20-12)

A "misdirected claim" is a claim that has been submitted to the wrong place. This section summarizes the disposition of misdirected claims by B MACs, carriers, and DME MACs.

Each fee-for-service claims administration contractor is assigned a specific geographic and subject matter jurisdiction for claims processing. Physicians and other suppliers are required to submit claims to the contractor having the appropriate jurisdiction. Jurisdictional rules are specified in this Chapter at Section 10.

A contractor may not knowingly adjudicate a misdirected claim and, as such, upon receipt of such a claim, must dispose of the claim in accordance with the specifications of this section or other relevant instructions.

This section addresses the following types of misdirected claims:

1. *a CMS-1500 or electronic claim submitted to the wrong local contractor (Part B MAC or carrier);*
2. *a CMS-1500 or electronic claim submitted to a local contractor (Part B MAC or carrier) that should have been submitted to a DME MAC;*
3. *a CMS-1500 or electronic claim submitted to a DME MAC that should have been submitted to a local contractor (Part B MAC or carrier);*
4. *a CMS-1500 or electronic claim submitted to a local contractor (Part B MAC or carrier) that should have been submitted to the Railroad Retirement Board (RRB);*
5. *a CMS-1500 or electronic claim submitted to a DME MAC or a local contractor (Part B MAC or carrier) that should have been submitted the United Mine Workers of America (UMWA);*
6. *a CMS-1500 claim that should be submitted to a DME MAC that is submitted to the wrong DME MAC, and*

This subsection does not apply to:

1. *misdirected beneficiary-submitted claims. See Section 80.3.2 of this Chapter regarding handling of such claims;*
2. *electronic claims for durable medical equipment, prosthetics, orthotics, or supplies (DMEPOS) that are submitted to the incorrect DME MAC (misdirected DMEPOS claims are automatically routed to the appropriate DME MAC jurisdiction for processing);*
3. *a claim submitted to the wrong Part A MAC or fiscal intermediary (FI), including a regional home health intermediary (RHHI).*

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10.1.9.1 – A Local *B/MAC/*Carrier Receives a Claim *for* Services that are in Another Local *B/MAC/*Carrier's Payment Jurisdiction

(Rev. 2474, Issued: 05-18-12, Effective: 07-20-12, Implementation;-7-20-12)

When a local contractor (Part B MAC or carrier) receives a CMS-1500 or electronic claim for Medicare payment for items/services furnished outside of its payment jurisdiction, the claim shall be returned as unprocessable.

NOTE: This instruction also applies to claims for DMEPOS items/services that are appropriately billed to the B MAC/carrier, but are billed to the wrong B MAC/carrier payment jurisdiction.

Use the following messages for claims indicated above except for claims that are identified as UMWA or RRB claims:

Claim Adjustment Reason Code (CARC) 109 – Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.

Remittance Advice Remark Code (RARC) N104 - This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS Web site at *www.cms.gov*.

RARC MA130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.

10.1.9.2 – *A Local B/MAC/Carrier Receives a Claim for Services that are in A DME MAC's Payment Jurisdiction*

(Rev. 2474, Issued: 05-18-12, Effective: 07-20-12, Implementation;-7-20-12)

When a local contractor (Part B MAC or carrier) receives a CMS-1500 or electronic claim for Medicare payment for items/services that are in a DME MAC's payment jurisdiction, the claim shall be returned as unprocessable.

Use the following messages for claims indicated above except for claims that are identified as UMWA or RRB claims:

CARC 109 – Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.

RARC N104 - This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS Web site at www.cms.gov.

RARC MA130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.

10.1.9.3 – *A DME MAC Receives a Claim for Services that are in A Local B/MAC/Carrier's Payment Jurisdiction*

(Rev. 2474, Issued: 05-18-12, Effective: 07-20-12, Implementation;-7-20-12)

When a local DME MAC receives a CMS-1500 or electronic claim for Medicare payment for items/services that are in a Part B MAC or carrier's payment jurisdiction, the claim shall be returned as unprocessable.

Use the following messages for claims indicated above except for claims that are identified as UMWA claims:

CARC 109 – Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.

RARC N104 - This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS Web site at www.cms.gov.

RARC MA130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.

10.1.9.4 - A Local *B/MAC/*Carrier Receives a Claim for an RRB Beneficiary

(Rev. 2474, Issued: 05-18-12, Effective: 07-20-12, Implementation;-7-20-12)

When a local contractor (Part B MAC or carrier) receives a Form CMS-1500 or electronic claim that is identified as a RRB claim for Medicare payment that should be processed by the RRB contractor, the claim shall be returned as unprocessable.

Use the following messages:

CARC 109 – Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.

RARC N105 - This is a misdirected claim/service for a RRB beneficiary. Submit paper claims to the RRB carrier: Palmetto GBA, P.O. Box 10066, Augusta, GA 30999. Call 866-749-4301 for RRB EDI information for electronic claims processing.

RARC MA130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.

NOTE: CMS requests that when RRB receives a claim that is not for an RRB beneficiary that they return the claim to the sender and notify them that the claim must be submitted to the local *contractor (Part B MAC or carrier) or DME MAC* for processing.

10.1.9.5 - A Local *B/MAC/*Carrier/*DME MAC* Receives a Claim for a UMWA Beneficiary

(Rev. 2474, Issued: 05-18-12, Effective: 07-20-12, Implementation;-7-20-12)

When a local contractor (Part B MAC or carrier/DME MAC) receives a Form CMS-1500 or electronic claim that is identified as a UMWA claim for Medicare payment that should be processed by the UMWA, the claim shall be returned as unprocessable.

Use the following messages:

CARC 109 - Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.

RARC N127 – This is a misdirected claim/service for a United Mine Workers of America (UMWA) beneficiary. Please submit claims to them.

RARC MA130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.

10.1.9.6 - *Medicare Carrier or RRB-Named Carrier to Welfare Carrier*

(Rev. 2474, Issued: 05-18-12, Effective: 07-20-12, Implementation;-7-20-12)

When a Medicare carrier or RRB-named carrier receives a query reply from CMS that includes a disposition code 46 and a welfare administration carrier number, it transfers the claim to the welfare carrier and notifies the beneficiary. Any pertinent information received or developed is transferred with the claim.

This occurs only if there is a State welfare carrier and the individual is identified in the beneficiary master record as a State buy-in enrollee for that State. *For more information on the definition of a welfare carrier, refer to Pub. 100-04, Chapter 1, section 10.1.7.*

10.1.9.7 - Protests Concerning Transfer of Requests for Payment to Carrier

(Rev. 2474, Issued: 05-18-12, Effective: 07-20-12, Implementation;-7-20-12)

If Palmetto GBA receives a protest concerning the transfer of a request for Medicare payment to the carrier, the protest, including pertinent name and claim number(s) information, is forwarded to:

Railroad Retirement Board
Medicare Section
844 Rush Street
Chicago, IL 60611

10.1.9.8 - Transfer of Claims Material Between Carrier and Intermediary (FI)

(Rev. 2474, Issued: 05-18-12, Effective: 07-20-12, Implementation;-7-20-12)

If a beneficiary erroneously submits a Form CMS-1490 (beneficiary-filed claim form) to a carrier with an itemized bill for services that must be paid by the FI, the carrier forwards such claims to the FI for the necessary action. The FI will inform the provider to submit a claim once the information is received from the carrier.

If the claim covers a combination of services both within and outside the carrier's jurisdiction the carrier should retain the Form CMS-1490 and any claims material needed for processing and forward a photocopy of the Form CMS-1490 and other claims materials to the other involved carrier(s) or FI(s). The carrier should notify the beneficiary when it transfers the claim.

The patient's signature on the Form CMS-1490 satisfied the signature requirement and protects the filing date for the provider billings. (See §70.1 for time limitations for filing claims).

10.1.9.9 - A DME MAC receives a Paper Claim with Items or Services that are in Another DME MAC's Payment Jurisdiction

(Rev. 2474, Issued: 05-18-12, Effective: 07-20-12, Implementation;-7-20-12)

When a DME MAC receives a claim submitted on the Form CMS-1500 for Medicare payment that should be processed by a DME MAC but was sent to the wrong DME MAC, the claim shall be returned as unprocessable.

Use the following messages:

CARC 109 – Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.

RARC N104 - This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS Web site at www.cms.gov.

RARC MA130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.

DME MACs shall continue to follow existing procedures for misdirected beneficiary-submitted claims and electronic claims.

80.3.2 - Handling Incomplete or Invalid Claims

(Rev. 2474, Issued: 05-18-12, Effective: 07-20-12, Implementation;-7-20-12)

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 Remittance Advice Remark 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 each surgical or medical service or supply furnished; charge for each service; treating doctor's or supplier's name and address; diagnosis code; procedure code and the provider or supplier's 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.)

D. Misdirected Claims

See §10.1.9 for instructions on handling claims that are submitted to the wrong contractor, or to the wrong payment jurisdiction.