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# CMS Manual System

## Pub. 100-04 Medicare Claims Processing

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

Transmittal 332

Date: October 22, 2004

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CHANGE REQUEST 3416

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

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

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

**IMPLEMENTATION DATE:** April 4, 2005

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

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

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	1/60 - Provider Billing of Noncovered Charges to Fiscal Intermediaries
R	1/60.1 - General Information on Institutional Noncovered Charges
R	1/60.1.1 - Notification Requirements Related to Noncovered Charges Prior to Billing

N	1/60.1.3.1 – Provider-liable Fully Noncovered Outpatient Claims
R	1/60.1.4 - Summary of All Types of Institutional No Payment Claims
R	1/60.1.5 - General Operational Information on Institutional Noncovered Charges
R	1/60.3 - Noncovered Charges on Institutional Demand Bills
R	1/60.3.1 - Traditional Demand Bills (Condition Code 20)
R	1/60.3.3 - Summary of Methods for Institutional Demand Billing
R	1/60.4.2 - Line-Item Modifiers Related to Reporting of Noncovered Charges When Covered and Noncovered Services Are on the Same Institutional Claim
R	1/60.4.3 - Clarifying Institutional Instructions for Outpatient Therapies Billed as Noncovered, on Other than HH PPS Claims, and for Critical Access Hospitals (CAHs) Billing the Same HCPCS Requiring Specific Time Increments
R	1/60.4.4 - Instructions for Noncovered Charges on Institutional Ambulance Claims
N	1/60.4.6 - Clarification on Notice Requirements Related to Billing Noncovered Charges for “Bundled” Institutional Benefits: Laboratory and Rural Health Clinic (RHC)/Federally Qualified Health Clinic (FQHC) Examples

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

**IV. ATTACHMENTS:**

X	<b>Business Requirements</b>
X	<b>Manual Instruction</b>
	<b>Confidential Requirements</b>
	<b>One-Time Notification</b>
	<b>Recurring Update Notification</b>

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

# Attachment - Business Requirements

Pub. 100-04	Transmittal: 332	Date: October 22, 2004	Change Request 3416
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**SUBJECT: New Policy and Refinements on Billing Noncovered Charges to Fiscal Intermediaries (FIs)**

## I. GENERAL INFORMATION

**A. Background:** Basic comprehensive instructions on billing noncovered charges to FIs are found in Chapter 1, Section 60 of Medicare's On-line Publication 100-04 on Claims Processing. These instructions, effective October 2003 as Transmittal R25CP, summarized several prior program memoranda. The scope of all these instructions is limited to institutional fee-for-service claims, not other types of transaction using claim formats.

Since publication of the summary instructions and one clarification, Transmittal R133CP effective April 2004, CMS has become aware of a few other required refinements, in addition to some new needs. These issues are:

- Allowing totally noncovered provider-liable outpatient claims without either condition codes 20 or 21 – NEW;
- Providing additional guidance on billing bundled services related to an ABN, with specific examples for rural health clinics (RHCs), federally qualified health clinics (FQHCs) and laboratory panel tests billed on institutional claims – REFINEMENT;
- Bypassing of some edits related to noncovered ambulance line items using the –QM or –QN modifiers – REFINEMENT;
- Other updates to website addresses, conforming text and comparable administrative changes.

Finally, though the basic principles of billing noncovered charges are static, this aspect of billing will continue to be subject to some adjustment due to changes in related policy areas-- as true with any type of billing. For example, as CMS refines its beneficiary financial protection notices, such as the Advance Beneficiary Notices (ABNs) and Notice of Exclusion from Medicare Benefits (NEMBs) listed on the [www.cms.hhs.gov/medicare/bni/](http://www.cms.hhs.gov/medicare/bni/) website, policy on billing noncovered charges will also be subject to review, and potentially change, since it is intertwined with these notices in terms of determination of liability. Policy related to ABNs and similar notices has been evolving rapidly since 2000, and the ramifications of changes in this policy area for billing are likely to continue into 2005.

**B. Policy:** This instruction supplements previous transmittals R25CP and R133CP (Change Requests--CRs-- 2634 and 3115 respectively). It also serves to effect compliance with the Health Insurance Portability and Accountability Act (HIPAA), in assuring all services not covered by Medicare may be submitted and accepted on Medicare claims, which in turn can be crossed-over to subsequent payers.

**C. Provider Education:** A Medlearn Matters provider education article related to this instruction will be available at [www.cms.hhs.gov/medlearn/matters](http://www.cms.hhs.gov/medlearn/matters) shortly after the CR is released. You will receive notification of the article release via the established "medlearn 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 must be included in your next regularly scheduled bulletin. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.

**II. BUSINESS REQUIREMENTS**

*"Shall" denotes a mandatory requirement*  
*"Should" denotes an optional requirement*

Require ment Number	Requirements	Responsibility (place an "X" in the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3416.1	Contractors shall allow totally noncovered outpatient claims with no-pay code "N" to be accepted and processed to completion as long as either: (1) condition code 20 or 21 appear on the claim; (2) no other indicators appear at the claim or line level to indicate a possibility of beneficiary liability; or (3) all indicators at the claim or line level indicate provider, not beneficiary, liability.					X				
3416.1.1	Contractors shall deny with line-level reason codes all these line items, and follow previously established instructions relative to indicators on the claim and/or systems defaults to determine liability, including review of claims using condition code 20.					X				

Requirement Number	Requirements	Responsibility (place an "X" in the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3416.2	Contractors shall bypass FISS reason code 31322 when modifiers –QM or –QN are present on ambulance service lines billed as noncovered so that these items/claims can process to completion.					X				
3416.2.1	Contractors shall place condition code 15 on any ambulance claims with noncovered charges suspended due to this reason code since CR 2634 went into effect October 2003 so that providers are paid interest on any covered services on those claims that process to completion when the bypass is in place.	X								

### III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

#### A. Other Instructions:

X-Ref Requirement #	Instructions
3416.1	<p>(1) Is a currently established processing requirement—re: CWF, see NOTE below, and (2) and (3) are new. Note that the default in FISS for denied items when liability is not specified is provider, not beneficiary. Currently, there are no claim-level indicators required by Medicare to indicate provider liability valid on all outpatient types of bills (for list of outpatient bill types, see 100-04/1/60.4). Current line-level indicators of provider liability on noncovered lines are modifiers -EY, -GZ, -QL, -TQ, and the HCPCS code A9270, IF no modifier is present with A9270 indicating beneficiary liability.</p> <p><b>NOTE:</b> The following was confirmed by the CWF maintainer: if the outpatient claim is totally noncovered with N NO-Pay Code then the requirement does not impact CWF, this is already in place. If any other No-Pay codes are applied, the claim will not bypass the edits in CWF.</p>

3416.1.1	<p>Claims using condition code 20 are subject to medical review and procedures cumulatively specified in previously received noncovered charge instructions in, or associated with, transmittals including R25CP and R133CP. Services subject to medical review may be subject to various determinations/adjudicative actions including payment, denial, return or rejection.</p> <p>From FISS: Currently claims with noncovered revenue lines submitted with condition code 20 are assigned a line-level denial. Then the claims are submitted for medical review. [Medical review may find some charges are covered and has separate instruction as to handling these claims.] ...If a line-level denial is not assigned to the claims submitted with non-covered revenue lines on condition code 20, the claim would suspend with FISS reason code 31955 and not process to medical review. The current infrastructure of the FISS requires that all provider-submitted noncovered charges be assigned a line-level denial reason.</p>
3416.2	<p>Currently, when either ambulance origin or destination modifiers are used, which are HCPCS modifiers composed of two varying one-digit fields, that are in the range of fixed two-digit HCPCS modifiers that are noncovered by definition, they are not processing because of edits associated with reason code 31322, Since -QM and -QN are used exclusively on these line items, the edit associated with this reason code can be bypassed by keying on these specific modifiers.</p>

**B. Design Considerations: N/A**

X-Ref Requirement #	Recommendation for Medicare System Requirements

**C. Interfaces: N/A**

**D. Contractor Financial Reporting /Workload Impact: N/A**

**E. Dependencies: N/A**

**F. Testing Considerations: N/A**

#### IV. SCHEDULE, CONTACTS, AND FUNDING

<p><b>Effective Date*:</b> April 1, 2005 for timely claims received on or after that date, or ambulance claims suspended as of that date with FISS reason code 31322, with dates of services on or after October 1, 2000.</p> <p><b>Implementation Date:</b> April 4, 2005</p> <p><b>Pre-Implementation Contact(s):</b> Elizabeth Carmody, 410-786-7533, <a href="mailto:ecarmody@cms.hhs.gov">ecarmody@cms.hhs.gov</a>; Cindy Murphy, 410-786-5733, <a href="mailto:cmurphy1@cms.hhs.gov">cmurphy1@cms.hhs.gov</a>.</p> <p><b>Post-Implementation Contact(s):</b> Regional Office</p>	<p><b>These instructions shall be implemented within your current operating budget.</b></p>
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**\*Unless otherwise specified, the effective date is the date of service.**

*60 - Provider Billing of Noncovered Charges to Fiscal Intermediaries*

*60.1 - General Information on Institutional Noncovered Charges on Institutional Claims*

60.1.1 - Notification Requirements Related to Noncovered Charges Prior to Billing

60.1.2 - Services Excluded by Statute

60.1.3 - Claims with Condition Code 21

*60.1.3.1 – Provider-liable Fully Noncovered Outpatient Claims*

*60.1.4 - Summary of All Types of Institutional No Payment Claims*

*60.1.5 - General Operational Information on Institutional Noncovered Charges*

60.2 - Noncovered Charges on Inpatient Bills

*60.3 - Noncovered Charges on Institutional Demand Bills*

*60.3.1 - Traditional Institutional Demand Bills (Condition Code 20)*

60.3.2 - General Demand Billing Instructions, Inpatient and Outpatient (Other than HH PPS and Part A SNF)

*60.3.3 - Summary of Methods for Institutional Demand Billing*

60.4 - Noncovered Charges on Outpatient Bills

60.4.1 - Billing with an ABN (Use of Occurrence Code 32) Comparable to Traditional Demand Bills

*60.4.2 - Line-Item Modifiers Related to Reporting of Noncovered Charges When Covered and Noncovered Services Are on the Same Institutional Claim*

*60.4.3 - Clarifying Institutional Instructions for Outpatient Therapies Billed as Noncovered, on Other than HH PPS Claims, and for Critical Access Hospitals (CAHs) Billing the Same HCPCS Requiring Specific Time Increments*

*60.4.4 – New Instructions for Noncovered Charges on Institutional Ambulance Claims*

60.4.5 - Clarification of Liability for Preventive Screening Benefits Subject to Frequency Limits

*60.4.6 - Clarification on Notice Requirements Related to Billing*



*Noncovered Charges for “Bundled” Institutional Benefits: Laboratory and Rural Health Clinic (RHC)/Federally Qualified Health Clinic (FQHC) Examples*

60.5- Intermediary Processing of No-Payment Bills (Will be updated Jul 04. to see update click on section)

***60 - Provider Billing of Noncovered Charges to Fiscal Intermediaries***

*(Rev.332, Issued: 10-22-04, Effective: 04-01-05, Implementation: 04-04-05)*

***60.1 - General Information on Institutional Noncovered Charges on Institutional Claims***

*(Rev.332, Issued: 10-22-04, Effective: 04-01-05, Implementation: 04-04-05)*

Both covered and noncovered charges can appear on Medicare claims. Since claims are submitted for payment unless otherwise noted, noncovered charges only appear/are necessary on claims. Therefore other transactions using the claim form, not seeking payment, are not affected by noncovered charge instructions (i.e., Requests for Anticipated Payment (RAPs) for home health, Notice of Election (NOEs) for hospice).

Though payment is not requested when charges are billed as noncovered, notice requirements exist establishing payment liability between the beneficiary and provider for services that are noncovered under Medicare. Liability notices, such as the Part B ABN and other similar notices, only serve to ensure that providers can shift liability under §1862(a)(1) and §1879 of the Social Security Act (the Act) when billing for services delivered to Medicare beneficiaries, that are usually covered as part of established Medicare benefits, but are thought not to be covered for a specific reason stipulated in the ABN. *Denials can relate to services not being reasonable and necessary under §1862(a)(1) of the Act, §1862(a)(9) for custodial care, §1879(g)(1) for home care given to a beneficiary who is not homebound or intermittent, or §1879(g)(2) hospice care given to someone not terminally ill.*

**60.1.1 - Notification Requirements Related to Noncovered Charges Prior to Billing**

*(Rev.332, Issued: 10-22-04, Effective: 04-01-05, Implementation: 04-04-05)*

**A. Payment Liability Conditions of Billing:**

Before delivering any service, providers must decide which one of the following three conditions apply in order to properly inform Medicare beneficiaries as to their potential liability for payment according to notice requirements explained below:

TABLE 1:

CONDITION 1	CONDITION 2	CONDITION 3
Services are statutory exclusions (ex., not defined as part of a specific Medicare benefit) and billed as noncovered, or billed as noncovered for another specific reason not related to §1862(a)(1) and §1879 of the Act (see below)	A reduction or termination in previously covered care, or a determination of coverage related to §1862(a)(1), §1862(a)(9), §1879(g)(1) or §1879(g)(2) will require a liability notice (i.e., ABN) OR a beneficiary requests a Medicare determination be given for a service that MAY be noncovered; billing of services varies	Services billed as covered are neither statutorily excluded nor require a liability notice be given
Potential liability: Beneficiary, as services are always submitted as noncovered and therefore always denied by Medicare	Potential liability: Beneficiary, subject to Medicare determination, on claim: If a service is found to be covered, the Medicare program pays	Potential liability: Medicare, unless service is denied as part of determination on claim, in which case liability may rest with the beneficiary or provider

**NOTE:** Only one of these conditions can apply to a given service.

Billing follows the determination of the liability condition and notification of the beneficiary (if applicable based on the condition). To the extent possible in billing, providers should split claims so that one of these three conditions holds true for all services billed on a claim, and therefore no more than one type of beneficiary notice on liability applies to a single claim. This approach should improve understanding of potential liability for all parties and speed processing of the majority of claims.

**EXCEPTION:** Cases may occur where multiple conditions may apply and multiple notices could be necessary. These are most likely to occur with claims paid under the outpatient prospective payment system (OPPS, §170 of Chapter 4 of this manual), *or the use of certain occurrence span codes on inpatient claims*. The OPPS requires all services provided on the same day to be billed on the same claim, with few exceptions as already given in OPPS instructions (i.e.; claims using condition codes 21, 20, discussed below, or G0). Modifiers used to differentiate line items on single claims when multiple conditions or notices apply are discussed below.

Liability is determined between providers and beneficiaries when Medicare makes a payment determination by denying a service. Determinations must always be made on items submitted as noncovered (i.e., properly submitted noncovered charges are denied). These denials have appeal rights, such as any other denials. However, appeals rights in these cases are not expected to be used frequently since submitting services as

noncovered should indicate agreement of the beneficiary and provider that there is no expected Medicare payment and therefore no amount in dispute.

A rejection or “return to provider” (RTP) does not represent a payment determination. However, beneficiaries cannot be held liable for services that are never properly billed to Medicare, such that a payment determination cannot be made (i.e., a payment or a denial of payment). Rejected or RTP'ed claims can be corrected and re-submitted, permitting a determination to be made after resubmission. In some cases, beneficiaries may appeal rejections, but NEVER RTP'ed claims.

The FIs/RHHIs should not advise providers to independently cancel or adjust denied claims, such as when a line submitted as noncovered is denied, especially when a medical review determination or payment group or level would be altered. Other than exceptions noted in §130, “Adjustments” in this chapter, denied claims cannot be adjusted or resubmitted, since a payment determination cannot be altered other than by reconsideration or appeal, though providers may contact their FI/RHHI in cases of billing errors (i.e., a date typing error detected after finalization). In such cases, the FI/RHHI can consult with the provider and cancel the claim in its entirety, so that the provider can then replace the cancelled claim with a new and correct original claim.

Payment Liability Condition 1. There is no required notice if beneficiaries elect to receive services that are excluded from Medicare by statute, which is understood as not being part of a Medicare benefit, or not covered for another reason that a provider can define, but that would not relate to potential denials under §§1879 and 1862 (a) (1) of the Act. However, applicable Conditions of Participation (COPs) MAY require a provider to inform a beneficiary of payment liability BEFORE delivering services not covered by Medicare, IF the provider intends to charge the beneficiary for such services. Some examples of Medicare statutory exclusions include hearing aides, most dental services, and most prescription drugs for beneficiaries with fee-for-service Medicare prior to enactment and effectiveness of a drug benefit in 2006 under the Medicare Prescription Drug, Improvement and Modernization Act of 2003.

In addition to what may be required by the COPs, providers are advised to respect Medicare beneficiaries' right to information as described in “Medicare and You” [the Medicare handbook], by alerting them to potential payment liability. If written notification of potential liability for statutory exclusions is either required or desired, an explanation and sample voluntary notice suggested for this purpose can be found at the Centers for Medicare and Medicaid Services (CMS) Web site (see Notices of Exclusions from Medicare Benefits, NEMB):

- [www.cms.hhs.gov/medicare/bni/](http://www.cms.hhs.gov/medicare/bni/)
- Chapter 30 of this manual, Financial Liability Protections, §90

When such a notice is given, patient records should be documented. If existing, any other situations in which a patient is informed a service is not covered, should also be

documented, making clear the specific reason the beneficiary was told a service would be billed as noncovered.

Payment Liability Condition 2. Providers must supply a liability notice if services delivered to a Medicare beneficiary are to be reduced or terminated following delivery of covered care, or thought not to be covered under §1862 (a) (1) of the Act, in order to shift liability under §1879. Providers must give these notices before services are delivered for which the beneficiary may be liable. Failure to provide such notices when required means the provider will not be able to shift liability to the beneficiary.

Over time, there have been two different types of such notices, given in different settings for specific types of care:

(1) Notices of non-coverage have been given to eligible inpatients receiving or previously eligible for non-hospice services covered under Medicare Part A (types of bill (TOB) 11x, 18x, 21x, and 41x) but services at issue no longer meet coverage guidelines, such as for exceeding the number of covered days in a spell of illness. In hospitals, these notices are known as Hospital Issued Notice of Non-coverage (HINNs) or hospital notices of non-coverage, in Skilled Nursing Facilities (SNFs), they may be known as Sarrasat notices. Providers have flexibility in delivering this notice: current CMS policy on such notices and comparable forms can be found at:

- Chapter 3 (Inpatient Hospital), §130.5, of the MCPM (these notices have been called HINNs);
- Chapter 30 of the Medicare Claims Processing Manual, §70-80.

**NOTE:** Medicare instructions are accessible at the following website:

[www.cms.hhs.gov/manuals/](http://www.cms.hhs.gov/manuals/)

(2) Outpatient ABNs, including HHABNs, are specific forms required by Medicare for providers to give to beneficiaries when: (a) Overall medical necessity of a recognized Medicare benefit is in doubt, under §1879 and §1862 (a) (1) of the Act, or (b) Care that was previously covered is to be reduced or terminated, usually because medical necessity for the service is doubted by the provider, or (c) The setting is inpatient such that other hospital and SNF specific forms are not applicable: Outpatient or Part B ABNs are used for certain Part B *services*-- including Part B SNF, HHA not under a plan of care, CORF and outpatient hospital, *or (d) hospice services ONLY among FI-billed services paid under Part A.* Current Part B - Outpatient ABN forms and instructions can be found on the CMS Web site on the ABN home page at:

- [www.cms.hhs.gov/medicare/bni](http://www.cms.hhs.gov/medicare/bni)
- Chapter 30 of the Medicare Claims Processing Manual, §40-50 (§60 is specific to the HHABN).

Payment Liability Condition 3. This condition is the case in which providers are billing for what they believe to be covered services as covered services. There are no notice requirements just for this condition, and noncovered charges are not involved. However, as mentioned before, there are cases in which covered and noncovered charges are submitted on the same claim.

**B. Summary of Notices by Provider Type:**

TABLE 2:

CONDITION	Notice	Type of Provider
Payment Liability Condition 1	No notice requirement—unless COPs require--not covered for reasons other than statute, §§1862(a)(1) and 1879 of the Act do not apply - documenting records recommended	All providers
Payment Liability Condition 1	Optional notice of services excluded by statute (ex., not part of a recognized Medicare benefit, may use NEMB, Form CMS-20007)	All providers when service known not to be covered by law by the Medicare fee-for-service program
Payment Liability Condition 2	Notice of Non-Coverage or comparable <i>form</i>	Inpatient only (TOBs: 11x, 18x, 21x, 41x)
Payment Liability Condition 2	HHABNs (Form CMS-R-296)	Home Health (HH) services under a HH plan of care and paid through the HH prospective payment system (PPS) only (TOBs 32x and 33X)
Payment Liability Condition 2	ABNs (Form CMS-R-131-L)*	Laboratories or providers billing lab tests only (revenue codes 30x, 31x and 92x)
Payment Liability Condition 2	ABN (Form CMS-R-131-G), CMS Form 10055 for SNF Part B services ONLY	All other providers and services, outpatient and inpatient Part B, not previously listed in this chart for Condition 2, that bill FIs or RHHIs, including HH services not under a plan of care, and hospice

		services paid under Part A
Payment Liability Condition 3	No notice requirement	All providers

\* Use of this version of the form is optional. Providers delivering same-day lab and non-lab services related to an ABN may use CMS-R-131-G for both.

### ***60.1.3.1 – Provider-liable Fully Noncovered Outpatient Claims***

***(Rev.332, Issued: 10-22-04, Effective: 04-01-05, Implementation: 04-04-05)***

*Originally with the creation of the ability of outpatient institutional providers to submit noncovered charges, only two types of fully noncovered claims were permitted: (1) No payment claims using condition code 21, or (2) Demand bills (see 60.3 below in this chapter). However, based on input from both FIs and providers, CMS subsequently recognized the need for entirely noncovered claims that could be assured to be provider-liability, since no payment claims with condition code 21 are never provider liable, and liable on demand bills cannot be assured until after review/adjudication by Medicare. A primary example of this need is a case in which a provider has failed to provide an ABN when required, and chooses to accept all liability for such services billed as noncovered.*

*Therefore, entirely noncovered outpatient claims are also allowed when billed with all noncovered charges, as long as either: (1) There are no indicators of liability on the claim at the claim or line level (the shared system will default in this case to holding providers liable on all denied line items); or (2) All indicators at the claim or line level indicate provider, not beneficiary, liability. An example of such an indicator is the -GZ modifier, which is often used in the case where a provider fails to give an ABN (see 60.4.2 below in this chapter). In both cases, these line items, all submitted as noncovered, will be denied.*

### ***60.1.4 - Summary of All Types of Institutional No Payment Claims***

***(Rev.332, Issued: 10-22-04, Effective: 04-01-05, Implementation: 04-04-05)***

Entirely noncovered ***inpatient*** claims submitted to Medicare ***often*** use frequency code 0 (zero), unless: (1) “7” for adjustments or “8” for cancellations are applicable, or (2) “traditional” condition code 20 demand bills applies, ***or (3) condition code 21 applies***. All outpatient, inpatient Part B and hospice TOBs must use either condition code 20 or 21, ***or be submitted as totally noncovered without any indicators of liability or with only indicators designating provider liability***, if claims are submitted as entirely noncovered.

TABLE 3:

Noncovered Indicator for Entire Claim	Table 1 Payment Liability Condition/Notice Requirements	Charges/Provider	Outcome/Liability
<p>Frequency Code 0 on Inpatient Hospital, Swing Bed, RNHCI or SNF Claims</p>	<p>Condition 1 – Noncovered claim for which provider is liable, NO notice requirement</p> <p>OR</p> <p>Condition 1 - Updating utilization of an inpatient benefit with a claim</p> <p>AND</p> <p>Condition 2 - Notice of non-coverage or equivalent form</p>	<p>All charges submitted as noncovered; use only for inpatient Part A services (i.e., TOB 11x, 18x, 21x, 41x)</p>	<p>Medicare will deny all services on such bills; provider or beneficiary liable, but the beneficiary must be given a notice of non-coverage before being held liable*</p>
<p>Condition Code 21 with Frequency Codes 7, 8, 0 (for entire noncovered claim)</p>	<p>Condition 1 – Voluntary notice of statutory exclusion</p> <p>OR any beneficiary or other payer requested billing for denial/no payment claim when no notice requirement exists (i.e., §1862(a)(1) or §1879 of the Act do not apply)</p> <p>OR Condition 2 – HHABN or SNFABN, Option A on form, custodial care only</p>	<p>All charges for all line items on claims using this code must be submitted as noncovered, all providers can submit**</p>	<p>Medicare will deny all services on these claims in all cases and will hold beneficiary liable for payment on these denials</p>

Condition Code 20 on finalized Claims with applicable Frequency Code***, or Frequency Code 7 or 9 on some HH PPS Demand Bills***	Condition 2 – HHABN for other than custodial care OR beneficiary-requested demand billing when neither HHABN nor other type of ABN required	All traditional demand-billed charges must be submitted as noncovered, but other covered services may be submitted on the same claim for the same interval by all providers	Medicare will suspend all claims submitted with this code, services may or may not be reviewed, properly informed beneficiaries may be liable for services denied after suspense/review
<i>Provider-liable Outpatient Bills</i>	<i>Condition 1 – No notice requirement</i>	<i>All charges submitted as noncovered; use only for outpatient services (see 60.4 in this chapter)</i>	<i>Medicare will deny all services on such bills as provider liable</i>

\* Medicare only requires the beneficiary receive a notice if the denial is based on Condition 2.

\*\* Noncovered claims can only be submitted for OPPTS for days where no covered services are provided that same day.

\*\*\* Different frequency codes can be used with condition code 20 demand billing, however, entirely noncovered condition code 20 initial demand bills must use frequency code 0 or be HH PPS demand bills; HH PPS demand bills with frequency code 9 may be partially or entirely noncovered.

**NOTE:** For information on Condition Code 20 bills, see §60.3 in this chapter.

**NOTE:** Other than in Part A inpatient cases (TOBs 11x, 18x, 21x, and 41x), providers can submit no payment claims using condition code 21 simultaneously with claims for covered charges for the same beneficiary (i.e., split billing of covered and noncovered charges). However, such “simultaneous” claims should not contain any future dates in their statement periods (i.e., from and through dates), and noncovered claims should fit within or be equal to the statement period of simultaneous for payment claims (i.e., not overlap the statement periods of multiple claims). This is because, though unusual, no payment claims may still be appealed, potentially overturned on appeal, and no more than one claim/statement period should be subject to change if this occurs. This is particularly important for claims paid prospectively (i.e., HH PPS).



All submitted noncovered or no payment claims using condition code 21 will be processed to completion, and all services on those claims, since they are submitted as noncovered, will be denied. The default liability for payment of these claims is assigned to the beneficiary, who may then submit the denial from Medicare, as the primary payer, to subsequent payer(s) for consideration. Since a denial is a Medicare determination of payment, all services submitted on no payment claims may be appealed later if unusual circumstances so warrant. That is, all payment determinations are subject to appeal, even denials of services submitted as noncovered.

### ***60.1.5 - General Operational Information on Institutional Noncovered Charges***

***(Rev.332, Issued: 10-22-04, Effective: 04-01-05, Implementation: 04-04-05)***

#### **A. Processing of Noncovered Charges in Medicare Claims Processing Systems**

Questions have been raised as to whether noncovered charges are subject to all the same software modules and edits in processing as covered charges. The answer is no, but processing varies depending on how the noncovered charge is submitted.

Medicare uses code editors to assure policy requirements are met in processing claims. These requirements are expressed as edits in software reviewing procedural and diagnostic coding. The Medicare Code Editor (MCE) is a module used on inpatient claims, and the Outpatient Code Editor (OCE) is used on outpatient claims. Entirely noncovered claims are not processed through OCE, though noncovered charges on claims with covered charges will process through these modules. However, entirely noncovered demand bills using condition code 20 may ultimately be submitted to these modules after review if some charges are judged covered.

There are 2 versions of the OCE, and most outpatient claims for various Medicare benefits flow through the OPSS OCE, not just OPSS claims. The OPSS OCE has two different edits that are applied to noncovered charges on claims with some covered charges (Edits 9 and 50). However, several OCE indicators may be applied to noncovered charges, and therefore there is no one-to-one correspondence of these indicators to specific scenarios for submission of noncovered charges, even statutory exclusions. These noncovered charges will be flagged for denial at this point or in subsequent processing.

Shared systems, also called standard systems, software forms the backbone of Medicare claims processing for Medicare institutional services. These systems link components of processing, such as code editors, Pricers, CWF, PS&R and the back-end remittance and MSN notices, and contain their own edits to assure accurate processing. Duplicate edits look for simultaneous services or claims submitted by the same provider for the same beneficiary. Entirely noncovered claims and line items, except condition code 20

demand bills, are not subject to these duplicate edits. Condition code 20 demand bills must be subject to these edits, since some services may be judged covered upon review.

Pricer software calculates the payment Medicare will make on a claim for many of Medicare's payment systems (i.e., OPSS). Neither entirely noncovered claims, nor noncovered line items, are processed through Pricer software.

The CWF is the segment of Medicare claims processing where several aspects of policy required for payment relative to a specific beneficiary are verified. For example, lifetime reserve days must be tracked for a beneficiary no matter what FI *is* involved in processing claims using these days. The CWF also has its own consistency edits to assure accurate payment and processing. The CWF consistency edits will not be applied to entirely noncovered claims and line items unless these edits address the validity of required claim elements (i.e., HIC number, provider number). The CWF Part B duplicate edits will also NOT be applied to entirely noncovered outpatient claims and line items, unless the claim has completely redundant data of another claim, including the same ICN (internal control number). Noncovered outpatient claims and line items subject to utilization edits or A/B crossover edits will also be bypassed. However, utilization edits will not *be* bypassed when they either serve to apply hospice claims to hospice periods, or to confirm beneficiary entitlement for Medicare (i.e., if not entitled to Medicare, no need to edit for noncovered charges under Medicare).

Claims or lines rejected as a duplicate PAYMENT not currently sent to CWF do not need to be sent because of noncovered charges if fitting into the following categories:

- CWF and FI duplicates;
- CWF rejects for entitlement;
- CWF rejects for claims that overlap risk HMO periods;
- CWF rejects for hospice election periods; and
- CWF rejects for HH PPS Claims that overlap other HH PPS episodes.

The outpatient CWF records (HUOP and HUUH) have been expanded to create a noncovered revenue line field to accept and pass noncovered charges to the National Claims History (NCH) File. Non-payment codes are required in CWF records where no payment is made for the entire claim.

Claims with noncovered charges, other than the rejects listed above and submitted by providers or resulting from FI review or medical review (MR) must be forwarded to CWF with the appropriate American National Standards Committee, Accredited Standards Committee X12 (ANSI ASC X12) group, adjustment reason codes, as presented in Table 9 below and elsewhere in this instruction. This must be done for both noncovered charges and covered charges on otherwise covered claims, and entirely noncovered claims. FI shared systems must provide a complete CWF input record for

these claims, totaling the charges on the CWF input under revenue code 0001 (covered and noncovered). When claims are totally noncovered (TOB = XX0, condition code 21 *claims, entirely provider-liable noncovered outpatient claims* or some demand bills with condition code 20), the reasons for non-coverage are shown on the 0001 line. Currently, Medicare systems are limited to carrying no more than four ANSI ASC X12 reason codes per line. If the services on a claim are noncovered for multiple reasons requiring more than four codes, report the first four codes appearing on the claim on the 0001 line.

Both the shared systems and CWF react to CMS-created non-payment codes on entirely noncovered claims. Standard systems 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.

Other than the distinct codes used for Medicare Secondary Payer (MSP) cost-avoided claims, entirely noncovered outpatient claims use either a "N" or "R" no payment or "no-pay" code. The N and the R no-pay codes are defined in §60.5 in this chapter. These codes do not in themselves establish payment liability. The codes function more to relay how interacting parts of Medicare systems should process and account for entirely noncovered claims; for example, with regard to tracking Medicare savings or utilization.

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 no payment 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.

After processing is complete, remittance notices, in the electronic 835 remittance format, or standard paper format, are used to explain to providers the difference between the charges they submitted and what Medicare paid. The MSN is used to inform beneficiaries about payment for the services they received. Questions have been asked as to what remittance or MSN messages should be used for submitted noncovered charges that are denied. Unless more specific applicable requirements already exist, the following remittance and MSN messages can be used for denied noncovered charges.

TABLE 4:

Liability	Remittance Requirement	MSN Message
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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 facturó este cargo como no cubierto. Usted no tiene que pagar esta cantidad.”

### **60.3 – Noncovered Charges on Institutional Demand Bills**

*(Rev.332, Issued: 10-22-04, Effective: 04-01-05, Implementation: 04-04-05)*

#### ***60.3.1 - Traditional Institutional Demand Bills (Condition Code 20)***

*(Rev.332, Issued: 10-22-04, Effective: 04-01-05, Implementation: 04-04-05)*

Traditional demand bills, a term being coined here to encompass the only billing option existing for demand bills before the ABN with outpatient billing, use condition code 20 to indicate a beneficiary has requested billing for a service, even though the provider of the service has advised the beneficiary Medicare is not likely to pay for this service. That is, there is some dispute as to whether a service is covered or not, because if there is no dispute, billing a no payment claim or other options for noncovered charges may be more appropriate.

In the past, traditional demand billing was not always consistent or used by all providers. There was no notice requirement. Past instructions required 100 percent of specific types of demand bills to be suspended for manual review (inpatient SNF/home health, TOBs 21x, 32x , 33x), and required the provider to submit additional documentation for development to determine the medical justification for the service(s) in question.

First, if an ABN is given, special billing requirements apply (see §60.4.1 in this chapter), and traditional demand billing should NOT be used. But now, only in cases when the ABN is NOT given, services for which coverage is questioned are submitted as noncovered using traditional demand billing. This process is now open to all provider types, inpatient, and outpatient. The case of demand billing with the HHABN, opposed to the ABN, is discussed under A. “Existing Demand Billing Instructions”, immediately below.

Even though there are no notice requirements with these demand bills, providers are always encouraged to advise beneficiaries when they may be liable for payment before delivering such services, and may be required to do so by applicable COPs. In such cases, providers should also document their records that such advice has been given.

General to all demand billing, use of defective HHABNs and ABNs to effect abusive demand billing is not permitted, since current ABN/HHABN policy states routine use of these forms is not acceptable (see §60.4.4.2, Chapter 30 (Limitation of Liability - Financial Liability Protections), of this manual). Routine use is defined in current ABN policy, and applies to all ABN forms (i.e., HHABN). If FIs/RHHIs find providers are making such use of the ABN or HHABN, they should first attempt to educate the provider. If the misuse continues, the FI/RHHI should expedite review in all subsequent cases and find the provider liable for all demand billed charges where routine use is made of the ABN or HHABN. Also in such cases, providers cannot retain any funds collected from the beneficiary in advance of a medical review decision on liability on a demand bill once a decision is made the beneficiary is not liable.

Demand billing is resource intensive for the Medicare program, and affects the timeliness of payment determinations, which should prevent conscientious providers from abusing this mechanism when there is no true doubt as to coverage/payment. Routine billing of covered services, or billing of noncovered charges as described in §60 of this chapter, should be used as appropriate when coverage/payment is not believed to be in doubt. The ABNs and HHABN are not needed in these two cases if a triggering event does not occur. Beneficiaries retain appeal rights when these other billing mechanisms are used.

#### **A. Previously Existing Demand Bill Instructions**

The CMS currently requires review and development of 100 percent of HH (TOBs 32x, 33x) and Part A SNF demand bills (TOB 21x).

1. HH PPS. There are special instructions for HH PPS demand bills. Such special instructions must be followed if: (a) An HHABN is required, or (b) If a beneficiary requests demand billing when receiving care from a home health agency (HHA) in an HH PPS episode. Instructions for such bills can be found at:

- §50 of Chapter 10 (Home Health) of the Medicare Claims Processing Manual; and
- Note these HH PPS demand bills use frequency code 9.

Note new exceptions for use of home health no payment bills in place of demand bills are described in Chapter 10, §60, of this manual.

2. SNF Demand Bills. There are special instructions for inpatient Part A SNF demand bills, which can be found at:

- Chapter 6 (Inpatient SNF), §40.7, of this manual, including use of no payment bill for custodial care; and
- *See also Chapter 30, §70 for Part B and General SNF ABN rules that may relate to SNF demand bills.*

Previous instructions may not have been precise with regard to timing of funds collected for SNF inpatient demand bills. In order to adhere to current policy in this chapter, §30.1.1, SNFs can only collect payment for noncovered charges billed on traditional demand bills when the beneficiary who received services is technically ineligible for Part A coverage. When a Part A inpatient is involved, the SNF may not collect funds until the intermediary has made a payment determination. This restriction is an exception to all other demand billing situations, where funds may be collected from beneficiaries in advance of the determination of liability resulting from medical review of a demand bill. If the result of such review is the beneficiary is not liable, any funds collected in advance must be returned.

***60.3.3 - Summary of Methods for Institutional Demand Billing***

***(Rev.332, Issued: 10-22-04, Effective: 04-01-05, Implementation: 04-04-05)***

Providers must decide which condition and notice requirement is appropriate to the billing situation, and use only one of these options in each case, as follows:

TABLE 5:

Situation and Notice Requirement	Description/Charges	Applicable Providers
No ABN or HHABN required, beneficiary not in a HH PPS episode, beneficiary in SNFPPS episode or otherwise requests a demand	Claims use condition code 20, and submit charges in question as noncovered in accordance with demand billing instructions	All outpatient/ hospice/inpatient providers except HHAs paid under HH PPS (i.e., all types of

bill be submitted (i.e., for a service excluded by statute)		bill (TOB) submitted to FIs/RHHIs EXCEPT 32x and 33x)
HHABN required OR service must be demand billed at beneficiary request during an HH PPS episode	Claims use condition code 20, and submit charges in question as noncovered according to directions for HH PPS demand bills	Only HHAs paid under HH PPS (TOB 32x and 33x only, frequency code 9)
Part B ABN required ( <i>i.e.</i> , 131-L --lab services only; 131-G)*  <b>NOTE:</b> Modifiers required when services not related to ABN must be billed on same claim	Claims use occurrence code 32, report the date the ABN was signed, and all services related to the ABN are submitted as covered charges	All outpatient/ hospice/inpatient Part B providers EXCEPT HHAs paid under HH PPS (i.e., all TOBs submitted to FIs/RHHIs except TOB 32x and 33x)

\* Use of this version of the form is optional. Providers delivering same-day lab and non-lab services related to an ABN may use CMS-R-131-G for both.

Same-day billing requirements under OPPS present a particular challenge. If a case occurred in which a OPPS hospital provided two services thought to be noncovered and in dispute on the same day, one for which an ABN was given and one without an ABN, the services would have to be submitted on two separate claims. One of these claims would be a demand bill using condition code 20 for the service not associated with the ABN, the other one a claim using occurrence code 32, which would contain the service associated with the ABN billed as covered, and could also contain other covered services provided that day (see Section III. H. below on the use of the –GA modifier). Both claims should process to completion, unless other edits apply, since claims using condition code 20 have always been exempted from the OPPS same day billing rule.

### ***60.4.2 - Line-Item Modifiers Related to Reporting of Noncovered Charges When Covered and Noncovered Services Are on the Same Institutional Claim***

*(Rev.)*

Several Healthcare Common Procedural Coding System (HCPCS) modifiers are used to signify a specific line item is either not covered or not payable by Medicare, for many different reasons. The chart immediately below lists all those modifiers, many more commonly used by Medicare carriers, for services not covered or not payable by Medicare. Modifiers not payable to carriers are also not payable to FIs/RHHIs, and will be denied if submitted on claims. Providers are liable for these denials, UNLESS a specific modifier (see second table in this section) or indicator on the claim (i.e., occurrence code 32) specifically attaches liability to the beneficiary. These modifiers,

not covered or payable by definition of the national HCPCS committee, along with other modifiers affecting payment that have been brought up in discussion of noncovered charges, are presented in the following chart:

TABLE 7:

***NOTE: This table does not include ambulance origin and destination modifiers, which may fall into the ranges of modifiers values below, but are NOT noncovered by definition.***

Source of the Modifier List	<i>Noncovered Modifiers</i>	Claims Processing Instructions	Definition Source
HCPCS Modifiers <u>Not Covered</u> or <u>Not Payable</u> by Medicare by <i>HCPCS</i> Definition ( <i>HCPCS</i> Administrative Instruction)	-A1 through -A9, -GY, -GZ, -H9, -HA through -HZ, -SA through -SE, -SH, -SJ, -SK, -SL, -ST, -SU, -SV, -TD through -TH, -TJ through -TN, - TP through -TW, -U1 through -U9, -UA through -UD	FI standard systems will deny all line items on all TOBs using these modifiers in all cases as part of processing claims (if not fully implemented before, all will be denied with the implementation of this instruction); provider liability is assumed EXCEPT when noted as beneficiary liable in accordance with the chart below (of the total set to the left: -GY, -TS)	Use as defined by publication of HCPCS codes by CMS
CPT/HCPCS Modifiers Permitted on OPPS Claims	<i>See current OPPS instructions subsequent to Transmittal A-02-129</i>	FI standard systems accept these modifiers for processing on OPPS claims (TOBs: 12, 13, 14) in accordance with HCPCS/CPT definitions	CPT numerical modifiers defined in publication of “CPT Manual” by the American Medical Association; HCPCS codes as defined by publication of HCPCS codes by CMS



Source of the Modifier List	<i>Noncovered</i> Modifiers	Claims Processing Instructions	Definition Source
Modifiers Used in Billing Ambulance Noncovered Charges (Transmittal A-02-113, new instructions below)	-GY, -QL, -QM* or -QN*, -TQ, alpha origin/destination modifiers*	Applicable TOBs for ambulance billing: 12x, 13x, 22x, 23x, 83x, 85x	See ambulance instructions (III. I.) and chart immediately below
Specific HCPCS Modifiers to Consider Related to Noncovered Charges or ABNs	-EY, -GA, -GK, -GL, -GY, -GZ, -KB, -TS	FI standard systems accept some of these modifiers for processing as specified on the chart below with the implementation of this instruction	See chart immediately below

\* These modifiers are not noncovered by definition, but rather are commonly used on noncovered lines

In the past, modifiers were more frequently used to qualify procedure codes submitted on professional billing formats, such as Form CMS-1500, to entities like Medicare carriers. Use of modifiers has increased in institutional billing over time, though, unlike professional claims, institutional claims did not always require the use of procedure codes in addition to revenue codes.

The Health Insurance Portability and Accountability Act (HIPAA) requires all submitters of electronic claims to use the 837 electronic format. The version of this format providers must use as of that time relates modifiers to associated procedure codes, including HCPCS (Form Locator 44 of the hard copy UB-92 claim). Therefore, HCPCS/procedural coding is required on any noncovered line item using one of the modifiers described in this instruction. In fact, the FI shared system will require procedure codes to be present any time a modifier is used, whether the line is covered or not.

Providers should use explicit procedure or HCPCS coding to describe services and items they deliver, even when submitting these items as noncovered. In cases in which general HCPCS coding may be needed to submit a noncovered service for which Medicare institutional claims have not required HCPCS coding in the past, such as with drugs or supplies, the following HCPCS code can be used with the appropriate revenue code in order to employ a modifier:

A9270 Noncovered item or service

FI/RHHI systems will accept this code, which, since it is noncovered by Medicare by definition, will be denied in all cases. Liability will rest with the provider, unless a modifier is used to assign liability to the beneficiary (i.e., -GL, -GY, -TS), when the beneficiary has been informed, prior to service delivery, that he/she may be liable for payment. Note -GA or -KB cannot be used with this code since they requires covered charges. Modifiers most likely to be used with *ABNs or* noncovered charges or liability notices are listed below.

TABLE 8:

Definition of Modifiers Related to Noncovered Charges/ABNs for FI/RHHI Billing

Mod -ifier	HCPCS Modifier Definition	HCPCS Coverage/ Payment /Admini- strative Instruction	Notice Requirement/ Liability	Billing Use	Payment Result
-EY	No Physician or Other Licensed Health Care Provider Order for this Item or Service	None	None, cannot be used when HHABN or ABN is required, recommend documenting records; liability is provider unless other modifiers are used ( -GL, -GY, or -TS)	To signify a line-item should not receive payment when Medicare requires orders to support delivery of a item or service (i.e., TOBs 21x, 22x, 32x, 33x, 34x, 74x, 75x, 76x, 81x, 82x, 85x)	When orders required, line item is submitted as noncovered and services will be denied
-GA	Waiver of Liability Statement on File	None	ABN required; beneficiary liable	To signify a line item is linked to an ABN when charges both related to and not related to an ABN must be submitted on the same claim	Line item must be submitted as covered; Medicare makes a determination for payment

Mod -ifier	HCPCS Modifier Definition	HCPCS Coverage/ Payment /Admini- strative Instruction	Notice Requirement/ Liability	Billing Use	Payment Result
-GK	Actual Item/Service Ordered by a Physician, Item Associated with a -GA or -GZ modifier	None	ABN required if -GA is used; no liability assumption since this modifier should not be used on FI claims	Use -GA or -GZ modifier as appropriate instead	Claims submitted to FIs using this modifier should be returned to the provider with the implementation of this instruction
-GL	Medically Unnecessary Upgrade Provided instead of Standard Item, No Charge, No ABN	None	Can't be used if ABN/HHABN is required, COPs may require notice, recommend documenting records; beneficiary liable	Use only with durable medical equipment (DME) items billed to the RHHIs (TOBs: 32x, 33x, 34x)	Lines submitted as noncovered and will be denied
-GY	Item or Service Statutorily Excluded or Does Not Meet the Definition of Any Medicare Benefit	Noncovered by Medicare Statute (ex., service not part of recognized Medicare benefit)	Optional notice only, unless required by COPs; beneficiary liable	Use on all types of line items on provider claims	Lines submitted as noncovered and will be denied

Mod <i>-ifier</i>	HCPCS Modifier Definition	HCPCS Coverage/ Payment/ Admini- strative Instruction	Notice Requirement/ Liability	Billing Use	Payment Result
-GZ	Item or Service Expected to Be Denied as Not Reasonable and Necessary	May be noncovered by Medicare	Cannot be used when ABN or HHABN is <i>actually given</i> , recommend documenting records; provider liable	Since with this instruction, condition code 20 demand bills can be submitted by all FI provider types, and these bills can accept covered and noncovered charges, and noncovered charges on these bills are already specified as requiring medical review, this modifier will not signal review is needed, but is available for optional use on demand bills NOT related to an ABN by providers who want to acknowledge they didn't provided an ABN for a specific line	Lines submitted as noncovered and will be denied
-KB	Beneficiary Requested Upgrade for ABN, more than 4 Modifiers on a Claim	None	ABN Required; if service denied in development, beneficiary assumed liable	Use only on line items requiring more than [2 or ] 4* modifiers on home health DME claims (TOBs 32x, 33x, 34x)	Line item submitted as covered, claim must suspend for development *
-QL	Patient pronounced dead after ambulance called	None	None, recommend documenting records; provider liable	Use only for ambulance services (TOBs: 12x, 13x, 22x, 23x, 83x, 85x)	Mileage lines submitted as noncovered and will be denied; base rate line submitted covered

Mod -ifier	HCPCS Modifier Definition	HCPCS Coverage/ Payment/ Admini- strative Instruction	Notice Requirement/ Liability	Billing Use	Payment Result
-TQ	Basic life support by transport by a volunteer ambulance provider	Not payable by Medicare	None, recommend documenting records; provider liable	Use only for ambulance services (TOBs: 12x, 13x, 22x, 23x, 83x, 85x)	Lines submitted as noncovered and will be denied
-TS	Follow-Up Service	Not payable by Medicare	No notice requirement, unless COPs require, recommend documenting records; beneficiary liable	Use on all types of provider claims when services are billed as noncovered for reasons other than can be established with other coding/modifiers (i.e., -GY) when the beneficiary is liable for other documented reasons	Lines submitted as noncovered and will be denied

\* **NOTE:** Many provider systems will not allow the submission of more than two modifiers. In such cases, despite the official definition and the capacity of the Medicare systems to take in four modifiers on a line with direct EDI submission, RHHs should educate that it is appropriate to use this modifier when three modifiers are needed if there is a two-modifier limit]

All modifiers listed in the chart immediately above that may be submitted on noncovered line items need only be used for Medicare when noncovered services cannot be split to entirely noncovered claims; however, modifiers indicating provider liability cannot be used on entirely no payment claims for which the beneficiary has liability.

In general, inappropriate use of these modifiers may result in entire claims being returned to providers. For example, if a modifier is required to be billed on a line with covered charges, and is billed with noncovered charges, the claims will be returned.

The modifier –GA should only be used when line items related to an ABN cannot be split to a separate claim with only services related to that ABN (occurrence code 32 demand bills). Occurrence code 32 must still be used on claims using the –GA modifier, so that these services can be linked to specific ABN(s). In such cases, only the line items using the –GA modifier are considered related to the ABN and must be covered charges, other line items on the same claims may appear as covered or noncovered charges. Both the –GA and –KB modifiers may suspend for review.

Modifier –GK should never be used on FI/RHHI claims. Claims using this modifier will be returned to providers for correction.

### ***60.4.3 - Clarifying Institutional Instructions for Outpatient Therapies Billed as Noncovered, on Other Than HH PPS Claims, and for Critical Access Hospitals (CAHs) Billing the Same HCPCS Requiring Specific Time Increments***

***(Rev.332, Issued: 10-22-04, Effective: 04-01-05, Implementation: 04-04-05)***

Claims for outpatient rehabilitative services, including certain audiology services and comprehensive outpatient rehabilitative facility (CORF) services, require billing with HCPCS procedure codes and line item dates, so that proper payment can be made under the Medicare Physician Fee Schedule. Complete instructions for many provider types for such billing can be found in §10 thru 40.5, Chapter 5 (Outpatient Rehabilitation) of this manual.

Though these instructions are still current and should be followed, they did not previously discuss billing for noncovered charges. This update to those instructions allows the submission of noncovered charges. Outpatient therapies billed as noncovered charges are not counted toward the therapy cap, when in effect, unless subject to review and found to be covered by Medicare-- note hospital bills are not subject to this cap. Modifiers presented in the previous section of this instruction can be used with therapies, in addition to therapy-specific instructions for the use of modifiers –GN, -GO and –GP

#### **Critical Access Hospitals (CAHs)**

Although CAHs are not addressed in §10-40.5, Chapter 5 (cited above), since they are not subject to payment on a fee basis under the Medicare Physician Fee Schedule, they sometimes bill therapies using HCPCS that by definition give specific time increments like those discussed below. Therefore, CAHs should follow the instructions below if there is a need to bill noncovered increments.

When HCPCS codes required for reporting do not specify an increment of billing in their definition (i.e., 15 minute intervals), the unit for the line item is 1, and general instructions given above for billing noncovered charges, either by the line item or on no payment claims, can be followed.

Several of the outpatient therapy HCPCS codes, however, do specify billing in specific time increments in their definition, and current instructions state units reported on line items should be consistent with these definitions. In such cases, when both covered and noncovered increments are provided in the same visit on the same date of service, billing should be done as follows:

- Use an ABN and modifiers when appropriate to explain non-coverage and payment liability of specific lines when covered and noncovered increments of the same visit appear on the same claim (i.e., -GY, see above);
- Report covered and noncovered units in separate line items, even when part of the same visit, with one line item for all covered and noncovered increments in a visit, and another for all noncovered increments in that same visit;
- Do not report noncovered line items that are part of a partially covered service on a separate no payment claim (i.e., using condition code 21); always report them on the same claim with the separate lines for the covered portion of the service, no payment claims received for the same date, same beneficiary, same provider and same therapy service as a for-payment claims will be processed to completion and rejected. A distinct reason code will make providers aware of the reason for the rejection, and they can correct their billing to have covered and noncovered portions of the same service on the same claim;
- Services of less than 8 minutes for codes defined in 15-minute increments could be billed as a separate line item of a single noncovered unit (i.e., noncovered charges are equal to total charges, service unit is 1), BUT such billing would be contrary to clinical and coding guidelines, and therefore should not be done;
- Do not report noncovered line items as part of the required reporting of value codes 50, 51 and 52 for covered visits (i.e., where all increments are noncovered and there are no covered charges for the line item, since these line items are either part of an already counted partially covered visit, or an entirely noncovered visit); and
- Never split a single increment into a covered and noncovered portion.

#### ***60.4.4 - New Instructions for Noncovered Charges for Mileage on Institutional Ambulance Claims***

***(Rev.332, Issued: 10-22-04, Effective: 04-01-05, Implementation: 04-04-05)***

Previous instructions presented one scenario in which noncovered ambulance miles would be billed: The statutory restriction that miles beyond the closest available facility cannot be billed to Medicare. This previous instruction only stated that noncovered miles beyond the closest facility had to be billed with HCPCS procedure code A0888 (“noncovered ambulance mileage per mile, e.g., for miles traveled beyond the closest appropriate facility”) on an entirely noncovered claim using condition code 21. While A0888 is still used for this purpose, and existing base ambulance requirements, such as reporting HCPCS, origin/destination and zip code, still stand, otherwise instructions for reporting ambulance noncovered mileage charges are presented in this section.

There is no longer any need for providers to use any other past instruction for submitting noncovered charges, such as forcing a one-dollar amount onto a noncovered line. Use of this mechanism will result in claims being returned *after October 2003*. Medicare will now process actual amounts of noncovered charges, when reported as such, in all cases.

Ambulance claims may use the –GY modifier on line items for such noncovered mileage, so that such items can be billed on claims also containing covered charges, and liability be assigned correctly to the beneficiary for such line item(s). This method of billing is preferable in this specific scenario, miles beyond the closest available facility, so that all miles for the same trip, perhaps with covered and noncovered portions, can be billed on the same claim. However, billing using condition code 21 claims will continue to be permitted, if desired, as long as all line items on the claims are noncovered and the beneficiary is liable. Additionally, unless requested by the beneficiary or required by specific Medicare policy, services excluded by statute do not have to be billed to Medicare.

When the scenario is point of pick up outside the United States, including U.S. territories but excepting some points in Canada and Mexico in some cases, mileage is also statutorily excluded from Medicare coverage. However, such billings are more likely to be submitted on entirely noncovered claims using condition code 21. Also, this scenario requires the use of a different message on the Medicare Summary Notice (MSN) sent to beneficiaries.

There is another straightforward scenario in which billing noncovered mileage to Medicare may occur. This is when the beneficiary dies after the ambulance has been called but before the ambulance arrives. *The* –QL modifier should be used on the base rate line in this scenario, in place of origin and destination modifiers, and is submitted with covered charges, but, with the implementation of this instruction, will also be used on the accompanying mileage line, if submitted, with noncovered charges. Submitting this noncovered mileage line is an option for providers, not a requirement, as with other outpatient noncovered charges.



The final scenario in which non-covered charges apply is if there is a subsidy of mileage charges that are never charged to Medicare. Because there are no charges for Medicare to share in, the only billing option is to submit noncovered charges, if billing is done at all (it is not required in such cases). These noncovered charges are not really charges, and therefore are unallowable, and should not be considered in settlement of cost reports. However, there is a difference in billing if such charges are subsidized, but otherwise would normally be charged to Medicare as the primary payer. In this latter case, CMS examination of existing rules relating to grants policy since October 1983, supported by federal regulations (42CFR 405.423), generally requires providers to reduce their costs by the amount of grants and gifts restricted to pay for such costs. Thereafter, section 405.423 was deleted from the regulations. Thus, providers were no longer required to reduce their costs for restricted grants and gifts, and charges tied to such grants/gifts/subsidies should be submitted as covered charges. This is in keeping with Congress's intent to encourage hospital philanthropy, allowing the provider receiving the subsidy to use it, and also requiring Medicare to share in the unreduced cost. Treatment of subsidized charges as non-covered Medicare charges serves to reduce Medicare payment on the Medicare cost report contrary to the 1983 change in policy.

Billing requirements for all these situations, including the use of modifiers, are presented in the chart below:

TABLE 9:

Mileage Scenario	HCPCS	Modifiers*	Liability	Billing	Remit. Requirements	MSN Message
STATUTE: Miles beyond closest facility,  OR  **Pick up point outside of U.S.	A0888 on line item for the noncovered mileage	-QM or  -QN, origin/destination modifier, and  -GY unless condition code 21 claim used	Beneficiary	Bill mileage line item with A0888 -GY and other modifiers as needed to establish liability, line item will be denied; OR bill service on condition code 21 claim, no -GY required, claim will be denied	Group code PR for patient responsibility, reason code 96: noncovered charges	16.10 "Medicare does not pay for this item or service"; OR, "Medicare no paga por este artículo o servicio"
Beneficiary dies after ambulance is called	Most appropriate ambulance HCPCS mileage	-QL unless condition code -21 claim	Provider	Bill mileage line item with -QL as noncovered, line item will be denied	Group Code CO for contractual obligation, reason code 96 for noncovered	16.58 "The provider billed this charge as noncovered. You do not have to pay this amount."; OR,

	code (i.e., ground, air)				charges	“El proveedor facturó este cargo como no cubierto. Usted no tiene que pagar esta cantidad.”
Subsidy or government owned  Ambulance, Medicare NEVER billed***	A0888 on line item for the noncovered mileage	-QM or -QN, origin/destination modifier, and  -TQ must be used for policy purposes	Pro- vider	Bill mileage line item with A0888, and modifiers as noncovered, line item will be denied	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 facturó este cargo como no cubierto. Usted no tiene que pagar esta cantidad.”

\* Current ambulance billing requirements state that either the -QM or -QN modifier must be used on services. The -QM is used when the “ambulance service is provided under arrangement by a provider of services,” and the -QN when the “ambulance service is provided directly by a provider of services.” *Line items using either the -QM or -QN modifiers are not subject to the FISS edit associated with FISS reason code 31322 so that these line items will process to completion.* Origin/destination modifiers, also required by current instruction, combine two alpha characters: one for origin, one for destination, *and are not noncovered by definition.*

\*\* This is the one scenario where the base rate is not paid in addition to mileage, and there are certain exceptions in Canada and Mexico where mileage is covered as described in existing ambulance instructions.

\*\*\*If Medicare would normally have been billed, submit mileage charges as covered charges despite subsidies.

Providers not complying with the requirements in the table may have their claims returned.

The use of the -TQ modifier is required so that CMS policy can track the instances of the subsidy scenario for non-covered charges. The -TQ should be used whether the subsidizing entity is governmental or voluntary. The -TQ modifier is not required in the case of covered charges submitted when a subsidy has been made, but charges are still normally made to Medicare as the primary payer.

If providers believe they have been significantly or materially penalized in the past by the failure of their cost reports to consider covered charges occurring in the subsidy case,

since Medicare had previous billing instructions that stated all charges in the case of a subsidy, not just charges when the entity providing the subsidy never charges another entity/primary payer, should be submitted as noncovered charges, they may contact their FI about reopening the reports in question for which the time period in 42 CFR 405.1885 has not expired. FIs have the discretion to determine if the amount in question warrants reopening. The CMS does not expect many such cases to occur.

#### ***60.4.6 Clarification on Notice Requirements Related to Billing Noncovered Charges for “Bundled” Institutional Benefits: Laboratory and Rural Health Clinic (RHC)/Federally Qualified Health Clinic (FQHC) Examples***

***(Rev.332, Issued: 10-22-04, Effective: 04-01-05, Implementation: 04-04-05)***

*Some Medicare payment policies or systems group or bundle several items or services into a single unit for payment; an example is a prospective payment system that pays a pre-determined amount independent of what particular services or items may be delivered in a given period of treatment. 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.*

*Regarding notification, §50.7.7.6 of Chapter 30 of this manual states: “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 from a beneficiary where full payment is made on a bundled basis would constitute double billing. An ABN may be used to shift liability [only] ... where part of the cost is not included in the bundled payment made by Medicare.” In short, an ABN has to apply to all of a bundled service, or none of it.*

*Billing follows notification. In terms of billing, this means all of a bundled service must be billed as noncovered, or none of it, since there is not a clear way for providers to dismantle bundled Medicare payment policies and associated billing requirements. 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 but does not seem to be medically necessary, then rules for billing in association with an ABN (see 60.4.1 in this Chapter) or demand billing (60.3 in this chapter) would apply. This last statement 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, and feels uncomfortable billing the entire bundle as covered for a specific reason.*

*Two specific areas that have raised questions regarding this policy are RHC/FQHC bundled encounter payments and lab panel tests. Many different professional services can be bundled into a RHC/FQHC encounter, and these providers are not required to provide service or item-specific detail on their claims, billing the entire encounter as a single line-item. Therefore, such encounters can only be billed as entirely covered, entirely non-covered, or billed in association with an ABN or demand billed if overall coverage is in doubt. However, if the majority of services provided in an encounter were known to be covered, even if some other services in the same encounter were thought to be noncovered though part of either the RHC or FQHC benefit, the entire bundle would be billed as covered on a single line item.*

*The same concept applies for lab panel tests. Medical necessity decisions are made relative to the appropriateness of the entire panel, not the individual tests comprised in the panel. However, such items may still be denied if, when considered in their entirety, the panel does not seem justified, and billing specific individuals test(s) would have been appropriate.*

