Medicare Claims Processing Manual

Chapter 2 - Admission and Registration Requirements

NOTE - Some of the material in this chapter about eligibility information may become outdated when HIPAA formats are fully implemented. This has not been deleted yet because the relative timing of issuance of this chapter and implementation of the ANSI X12N 270/271. There is also an issue currently pending about where to place the 270/271 instructions. Currently they are in draft Chapter 31.

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120.4 - Common Working File (CWF)

01 - Purpose of Chapter

(Rev. 1, 10-01-03)

This chapter describes general requirements with respect to verifying an individual's Medicare eligibility and entitlement status for providers, suppliers, FIs, and carriers. It also includes instructions for processing elections for Religious Nonmedical Health Care Institutions and general requirements for hospitals for determining the source admission for use later in the claims process.

05 - Definition of Provider and Supplier

(Rev. 1, 10-01-03)

This chapter uses the definition of provider and supplier found in 42 CFR 400.202. These are:

> **Provider** means a hospital, a CAH, a skilled nursing facility, a comprehensive outpatient rehabilitation facility, a home health agency, or a hospice that has in effect an agreement to participate in Medicare, or a clinic, a rehabilitation agency, or a public health agency that has in effect a similar agreement but only to furnish outpatient physical therapy or speech pathology services, or a community mental health center that has in effect a similar agreement but only to furnish partial hospitalization services.
>
> **Supplier** means a physician or other practitioner, or an entity other than a provider, that furnishes health care services under Medicare.

Note that while rural health clinics, Federally qualified health centers, and renal dialysis facilities are suppliers under the regulation, they submit most claims to FIs.

10 - General Admission and Registration Rules

(Rev. 1, 10-01-03)

HO-300, HO-312

The following is a general description of requirements and prohibited activities that apply to admission for inpatient services or registration for other healthcare services.

Upon admission, Prospective Payment System (PPS) hospitals and acute care hospitals in areas with waivers from PPS are required to give the notice, "An Important Message from Medicare," to beneficiaries (available at http://www.cms.hhs.gov/forms/). The facility inserts its Quality Improvement Organization's (QIO) name, address, and phone number. It provides this notice to each Medicare patient or the patient's representative. The CMS does not supply copies of the notice.

Upon admission of a Medicare beneficiary to an institution that bills Medicare, or as soon thereafter as practical, the provider must verify a patient's eligibility in order to process the bill. The provider may obtain this eligibility information directly from the patient or through the provider's Fiscal Intermediary's (FI) limited Medicare eligibility data. See §30.6. The provider contacts its FI to obtain technical instructions regarding how this access may be implemented along with hardware/software compatibility details.

This information does not represent a definitive eligibility status. If the individual is not on file, the provider uses the usual admission and billing procedure in effect, independent of this data access.

Disclosure of CMS eligibility data is restricted under the provisions of the Privacy Act of 1974. This information is confidential, and may be used only for verifying a patient's eligibility to benefits under the Medicare program. Penalties for misuse by anyone may result in being found guilty of a misdemeanor and paying a fine not more than $5,000.

10.1 - Health Insurance Claim Numbers (HICNs)

(Rev. 1, 10-01-03)

A3-3502, B3-3200, B3-3203, HO-304.4

The CMS maintains the electronic records for individuals enrolled in the health insurance program. The CMS issues health insurance cards where entitlement is established through the Social Security Administration (SSA), and the Railroad Retirement Board (RRB) issues health insurance cards where entitlement is established through RRB. Most HICNs are 9-digit numbers with letter suffixes, e.g., 000-00-0000-A. However, an HICN might also be a 6- or 9-digit number with letter prefixes, e.g., A-000000, A-000-00-0000; or WD-000000, WD-000-00-0000. When the status of a beneficiary changes, it is possible for the prefix or suffix of his/her claim number to change.

See Chapter 2 of the Medicare General Information, Eligibility, and Entitlement Manual (Pub. 100-1) for an extended discussion of HI cards and HICNs.

10.1.1 - Changes to HICNs

(Rev. 1, 10-01-03)

A3-3502.1, B3-3205, HO-304.5

Changes in an individual's entitlement to Medicare benefits may result in an individual being assigned a completely different HICN. For example, an individual not entitled to monthly benefits (000-00-0000T) marries and becomes entitled to wife's benefits on her husband's account (111-11-1111B). If a claim is submitted under the old HICN, the Common Working File (CWF) disposition code 51 will notify the FI or carrier (whom we will refer to jointly as the contractor when both are meant) of the new HICN. The

contractor will annotate its records and use the new HICN when submitting future bills or claims.

10.1.2 - Contractor Procedures for Obtaining Missing or Incorrect Claim Numbers

(Rev. 1, 10-01-03)

B3-3208

Upon receipt of a claim or other paper on which the health insurance claim number is omitted, incomplete, inconsistent, or obviously incorrect, the contractor submits the claim to CWF with the best information it has available. Depending on the CWF reply, the contractor follows the instructions in Chapter 27 for handling various disposition codes, trailers, and error codes.

10.1.3 - Importance of HICNs

(Rev. 1, 10-01-03)

HO-304, SNF-404

The HICN is used in Medicare records to identify the beneficiary. The provider or supplier obtains this number before billing. See §30 below for a description of appropriate processes for obtaining the HICN.

10.2 - Prohibition Against Waiver of Health Insurance Benefits as a Condition of Admission

(Rev. 1, 10-01-03)

HO-302, SNF-402

Providers may not require, as a condition of admission or treatment, that a patient agree to waive the right to have services paid for under Medicare. Requiring such a "waiver" is inconsistent with the agreement with CMS, and the "waiver" is not binding upon the patient. Providers have agreed not to charge an individual (except for specified deductible and coinsurance amounts) for services for which such individual is entitled to have payment made or for which he/she would be entitled if the provider complied with the procedural and other requirements of the program. Further, under this provision, the provider must refund any amounts incorrectly collected.

Where a patient who has signed such a waiver, nevertheless, requests payment under the program, the provider must bill the Medicare contractor and refund any payments made by the patient, or on the patient's behalf, in excess of permissible charges.

10.3 - Requiring Prepayment as a Condition of Admission is Prohibited

(Rev. 1, 10-01-03)

HO-303, SNF-317

Providers must not require advance payment of the inpatient deductible or coinsurance as a condition of admission. Additionally, providers may not require that the beneficiary prepay any Part B charges as a condition of admission, except where prepayment from non-Medicare patients is required. In such cases, only the deductible and coinsurance may be collected. Where the patient does not have Part B entitlement, the provider will follow the rules in §10.6.

10.4 - When Prepayment May Be Requested

(Rev. 1, 10-01-03)

HO-303.2

The provider may collect deductible or coinsurance amounts only where it appears that the patient will owe deductible or coinsurance amounts and where it is routine and customary policy to request similar prepayment from non-Medicare patients with similar benefits that leave patients responsible for a part of the cost of their hospital services. In admitting or registering patients, the provider must ascertain whether beneficiaries have medical insurance coverage. Where beneficiaries have medical insurance coverage, the provider asks the beneficiary if he/she has a Medicare Summary Notice (MSN) showing his/her deductible status. If a beneficiary shows that the Part B deductible is met, the provider will not request or require prepayment of the deductible.

Except in rare cases where prepayment may be required, any request for payment must be made as a request and without undue pressure. The beneficiary (and the beneficiary's family) must not be given cause to fear that admission or treatment will be denied for failure to make the advance payment.

Providers must insure that the admitting office personnel are informed and kept fully aware of the policy on prepayment. For this purpose, and for the benefit of the provider and the public, it is desirable that a notice be posted prominently in the admitting office or lobby to the effect that no patient will be refused admission for inability to make an advance payment or deposit if Medicare is expected to pay the hospital costs.

10.5 - Hospital and Skilled Nursing Facility (SNF) Verification of Prior Hospital Stay Information for Determining Deductible and Benefit Period Status

(Rev. 1, 10-01-03)

HO-300

If it has been determined that Medicare is the primary payer, the hospital or SNF must determine if the patient has been an inpatient in any hospital or SNF, including swing bed stays, during the prior 60 days. If so, the hospital or SNF must determine the admission and discharge dates and the number of days of hospitalization or skilled nursing (as applicable) the patient used in the current benefit period. The admission and discharge dates must be reported on the claim, and the number of days of hospitalization or skilled nursing (as applicable) must be used to calculate the hospital insurance copayment and the number of days remaining in the benefit period.

If the patient indicates he/she was not an inpatient within the last 60 days, the hospital applies the inpatient deductible to the current stay if it is a covered hospital admission. The FI determines the accuracy of the claim data after receipt of the claim. The remittance advice received from the FI reflects the amount of deductible (hospital claims) and coinsurance (hospital and SNF claims) applied. If this amount is different from what was billed, the hospital/SNF must correct the records accordingly.

10.6 - Hospitals May Require Prepayment for Noncovered Services

(Rev. 1, 10-01-03)

HO-303.3

With regard to noncovered services (e.g., personal comfort items, a private duty nurse), the hospital may deny such services for which the beneficiary has not paid or offered satisfactory assurance of payment if that is the hospital's practice with nonbeneficiary patients. For example, a private room or TV set need not be furnished to a patient who requests it but is unable to prepay or offer the assurance of payment which is usually required.

Where the individual has exhausted his/her covered inpatient hospital benefits, or cannot supply satisfactory evidence of entitlement under Part A, providers are free to apply to such persons the hospital's usual policy with respect to requiring prepayment or other assurance of payment where the patient has no insurance. In addition, for the beneficiaries receiving covered inpatient services who are not enrolled for medical insurance (Part B), the hospital can apply its usual policy on prepayment or assurance of payment with regard to services of salaried physicians provided.

10.7 - Compliance With Agreement

(Rev. 1, 10-01-03)

HO-303.4

Providers must conform to the policy set forth in this instruction. Noncompliance will be considered in determining whether the provider is honoring its agreement, under which it may not charge for services for which payment may be made under the Medicare program.

10.8 - Request for Payment Should Be Obtained in All Cases as Protective Application for Hospital Insurance Benefits

(Rev. 1, 10-01-03)

HO-266, HO-307, SNF-407

To become entitled to HI benefits, an individual must not only be eligible, but must also, prior to death, have filed an application for such benefits (or for monthly social security benefits). Even though the individual meets all eligibility requirements, if the individual does not file the necessary application before death, the individual cannot become entitled, and no payment can be made for hospital services. The provider should obtain a written request for title XVIII payment, filed by or on behalf of a patient, upon admission as described in Chapter 1.

Occasionally, a Medicare eligible patient age 65 or over who is admitted to a hospital, has never applied for benefits. A request for payment will protect the eligible patient, the patient's estate, and the provider against the possibility that timely application will not be filed. If the patient refuses to sign the request, the provider will respect the patient's wishes. The provider may then require the patient to pay or give assurance of payment in accordance with customary practice for non-beneficiaries. If the patient cannot sign, and is not accompanied by anyone who can sign on the patient's behalf, an authorized provider official may execute the request for payment on the patient's behalf. The admission record containing the request should contain the patient's name and be signed and dated as of the signature date.

Where the Social Security Office (SSO), upon the provider's inquiry for a claim number, finds that an apparently eligible inpatient has not applied for benefits; and that the filing date established by the written request might permit payment (not otherwise possible) for the individual's inpatient services; the SSO will ask the provider for a photocopy of the admission record containing the signed request. The SSO may ask the provider to file a prescribed application for benefits on behalf of the patient who is incompetent if there is no other qualified applicant.

In the case of a deceased patient, who prior to death signed a document that protected the filing date, a provider may apply on behalf of the patient if no other qualified applicant

applies within six months of the date of notice of the need for application. However, where a qualified survivor or representative of the estate refuses to file and states in writing that his/her refusal is based upon the fact that filing would be detrimental to the deceased's estate, hospital insurance entitlement cannot be established and payment cannot be made for services.

10.9 - FI Requests to Verify Patient's HICN

(Rev. 1, 10-01-03)

HO-308

Where the name and claim number information on a claim does not match the CMS central record, the FI will return the claim to the provider and request the provider to verify the information.

The provider will compare the name and number on the claim with that on provider records. If the information submitted was incorrect, the provider will return the claim to the FI with the corrected information.

If, however, the information in the provider's records identifying the patient is the same as the information submitted on the claim, the provider will contact the SSO for assistance.

10.10 - FI Learns Beneficiary is an HMO Enrollee

(Rev. 1, 10-01-03)

HO-309

If the FI determines from its records or its query to CMS that a patient is an HMO enrollee, the FI will return the claim to the provider with instructions to request payment from the HMO for payment, if appropriate.

10.11 - Retroactive Entitlement

(Rev. 1, 10-01-03)

HO-310, SNF-410

When an application for social security benefits is filed by a person 65 years of age or older, the person may inform the SSO that he/she received hospital services in the retroactive period of up to six months for which he/she may be entitled to benefits. In these cases, the provider may bill for covered retroactive services but must verify the patient's eligibility through the FI before billing. If the patient paid, the provider must refund the appropriate amount to the patient.

10.12 - SNF Verification of Prior Hospital Stay and Transfer Requirements

(Rev. 1, 10-01-03)

SNF-414

SNFs must verify that the beneficiary was discharged from a hospital with a transfer agreement with the SNF and that:

a. The date of discharge is on or after the first day of the month in which the beneficiary became entitled to Medicare;

b. The hospital stay was at least three calendar days in duration (hospital days to which waiver of liability was applied cannot be used to satisfy the 3-day requirement); and

c. The 3-day qualifying stay was within 30 days of the SNF admission, unless the rules for exception apply.

The hospital usually sends the SNF a patient transfer form or other record in accordance with the transfer agreement. The dates of the hospital stay are required on the claim.

For more information on the above criteria, see Chapter 8 of the Medicare Benefit Policy Manual.

20 - Obtaining Information to Determine Whether to Bill Medicare or Another Payer

(Rev. 1, 10-01-03)

HO-300, SNF-401

The provider must ascertain whether the patient is a member of a Medicare + Choice organization (M+CO). If the patient is a member of an M+CO, the provider must contact the M+CO specified by the patient or identified on the patient's membership card, so the provider may determine whether to submit the claim to the M+CO.

If the patient indicates that he/she is not a member of an M+CO, the provider, in order to determine whom to bill, develops for situations where Medicare is the secondary payer by obtaining answers to the "Admission Questions to Ask Medicare Beneficiaries" contained in Chapter 3 of the Medicare Secondary Payer Manual. If another insurer is identified as primary to Medicare, the provider follows the procedures in the Medicare Secondary Payer (MSP) Manual.

20.1 - Provider Development of Medicare Secondary Payer

(Rev. 1, 10-01-03)

HO-301, SNF-401, A-03-031

Medicare is the secondary payer under certain circumstances. See Medicare Secondary Payer (MSP) Manual, Chapter 1, for related instructions.

30 - Provider/Supplier Obtaining/Verifying the HICN and Entitlement Status

(Rev. 1, 10-01-03)

A3-3503, HO-304; **HO-311, SNF-404**

It is important that the patient's HICN be obtained and accurately recorded because the claim cannot be processed if the HICN is missing or incorrect. A social security number is not sufficient.

When a patient 65 years of age or over, or a younger patient who possibly has entitlement to Medicare as a disability beneficiary or under the provisions for coverage of persons needing a kidney transplantation or dialysis, is admitted or registered for services, the provider asks for the health insurance card, Temporary Notice of Medicare Eligibility, or other notice the patient has received from CMS or a FI or carrier which shows the claim number. If the patient cannot furnish the information, the provider contacts the SSO in accordance with §60. If a patient or prospective patient is within three months of age 65, or is disabled or has ESRD, and has not applied for HI entitlement, the provider advises the patient to contact the SSO, or to have someone do so on the patient's behalf. The provider may arrange with the SSO to routinely bring such cases to the SSO's attention.

This requirement also applies to inpatient services for which no payment is due because providers are required to submit inpatient claims even when benefits are exhausted or are not payable for some reason. The CMS requires this data to record necessary benefit information on CMS records. Where the patient refuses to request payment and refuses to furnish information about his/her HICN, the provider documents the records accordingly and attempts to get the HICN from the SSO.

30.1 - Cross-Reference of HICN

(Rev. 1, 10-01-03)

A3-3800.2, B3-6005.2

If a beneficiary's entitlement to Medicare has been transferred from one HICN to another, the CWF will cross-reference the old number to the new number. If there has been utilization of benefits under each number, all data will be combined under the new number.

A - Disposition Code 51

1 - If, after submitting the admission notice or Part B claim to CMS, the contractor receives a disposition code of 51 with trailer code 01 containing a possible HICN, the contractor investigates the new HICN, and if it believes the new HICN is correct, the contractor resubmits the claim under the new HICN. CWF responds with an appropriate disposition code and any associated trailers for processing the claim.

2 - If the contractor receives a disposition code of 51 without trailer code 01, or after investigation determines the HICN in the 01 trailer is incorrect, it denies the claim using the following message:

> Payment cannot be made for the services you received from (name of provider) because we have no record of your Medicare number. Please write your correct number on the claim and resubmit the claim to (name of provider). If you think the number is right, check with your local Social Security Office.

B - Disposition Code 55

If CWF returns disposition code 55 and trailer code 08 containing an error code of 5052, indicating a mismatch in the beneficiary's personal characteristics, CWF will also return to the contractor what it believes to be the proper information on trailer code 10. The header portion of the response also contains the corrected sex and birth date, if applicable, of the beneficiary.

The contractor investigates the information provided, corrects the information on the claim, and resubmits it to CWF. If the contractor continues to receive a code 55, it contacts the Host through locally established procedures. See Chapter 27.

30.2 - Health Insurance (HI) Card

(Rev. 1, 10-01-03)

A3-3501, B3-3200, HO-304

As part of health insurance electronic data processing, HI cards are issued by CMS (or by the RRB where railroad retirement beneficiaries are involved) to individuals who have established entitlement to health insurance. (See Chapter 2 of the Medicare General Information, Eligibility, and Entitlement Manual.) The health insurance card is used to identify the individual as being entitled and serves as a source of information required to process Medicare claims or bills. The health insurance card displays the beneficiary's name, sex, HICN, and effective date of entitlement to hospital insurance and/or medical insurance.

If the Medicare contractor receives an inquiry about replacing a lost or destroyed HI card, it informs the inquirer to get in touch with the SSO nearest the inquirer's address for

assistance. SSO addresses are generally listed in local telephone directories under "Social Security Administration."

A health insurance card is acceptable without a signature, but the provider will ask the patient to sign it.

30.3 - Temporary Eligibility Notice

(Rev. 1, 10-01-03)

A3-3501.1, B3-3200, HO-304.2

The SSO may issue a temporary health insurance eligibility notice, pending the issuance of a health insurance card, when the beneficiary is in need of immediate medical services. The provider may obtain the patient's name and claim number from the temporary eligibility notice. See Chapter 2 of the Medicare General Information, Eligibility, and Entitlement Manual for an example of the temporary notice.

For claims processed by the Medicare carrier, the individual, the individual's physician, or other supplier must show the health insurance claim number on the request for Medicare payment and on other related bills and documents. Because Health Insurance records are maintained by the individual's claim number, the claim number must be used on all communications.

30.4 - Certificate of Social Insurance Award

(Rev. 1, 10-01-03)

HO-304.3

Health insurance beneficiaries receive a Certificate of Social Insurance Award, SSA-30, showing the HICN, dates of entitlement to Part A and/or Part B benefits, and the following statement:

> This notice may be used if Medicare services are needed before you receive your health insurance card.

30.5 - Medicare Summary Notice (MSN)

(Rev. 1, 10-01-03)

HO-305

If patients cannot furnish their health insurance cards when admitted, they may have a MSN form showing the claim number. A notice is mailed to a beneficiary shortly after Part A or Part B benefits have been paid on the beneficiary's behalf. Deductible status is also shown on these forms.

30.6 - Provider Access to CMS and Carrier or FI Eligibility Data

(Rev. 1, 10-01-03)

A3-3508, B3-6100

The contractor will allow only Medicare certified providers as defined in §§1861 and 1866(e) of the Social Security Act (the Act) and their billing agents automated access to beneficiary eligibility data. Disclosure of CWF eligibility data is restricted under provisions of the Privacy Act of 1974, 5 U.S.C §552a. Under limited circumstances, the Privacy Act permits CMS to disclose information without consent of the individual. One circumstance is for "routine uses," that is, disclosure for purposes that are compatible with the purpose for which CMS collects the information. In the case of this provider access, a routine use exists which permits release of data to providers or their authorized billing agents for the purpose of verifying a patient's eligibility for benefits under the Medicare program. The use of the data by a provider in preparing claims for hospital-based physicians would be an example of unauthorized use because the physicians are not Medicare providers as defined in the Act.

FIs and carriers (contractors) will adjust their systems to accept the revised standard HIQA/HUQA records from the CMS CWF. The standard data elements to be made available to providers are listed below:

- HICN;
- Beneficiary:
    - Last name (first six positions)/first initial;
    - Date of birth;
    - Sex;
    - Date of death;
    - Lifetime reserve days remaining;
    - Lifetime psychiatric days remaining (requesting hospital must use a psychiatric provider number to obtain this data);
    - Cross reference HICN;
    - Current and prior A and B entitlements, with start and stop dates for Part A, Part B, ESRD, HMO, and hospice; and

- Spell of illness (applicable spell based on the date entered by the provider and the next most recent spell):
    - Hospital full days remaining;
    - Hospital coinsurance days remaining;
    - SNF full days remaining;
    - SNF coinsurance days remaining;
    - Part A cash deductible remaining to be met;
    - Date of earliest billing action for indicated spell-of-illness;
    - Date of latest billing action for indicated spell-of-illness;
    - Blood deductible (combined annual Part A and B remaining to be met for applicable year entered by provider);
    - Part B trailer year (applicable year based on date entered by provider);
    - Part B cash deductible;
    - Physical/speech therapy limit (physical therapy and speech therapy are applicable to physical therapy limit);
    - Occupational therapy limit;
    - Hospice data (applicable periods based on the date entered by the provider and the next most recent period);
    - ESRD indicator (shows beneficiary is currently entitled);
    - REP payee indicator;
    - MSP indicator;
    - Home Health Benefit Period:
        - Part A visits remaining;
        - Part B visits applied;
        - Date of earliest billing action for home health benefit period;

- Date of latest billing action for home health benefit period.

- HMO information (applicable periods based on date entered by the provider):
  - Name;
  - Identification number;
  - Zip Code;
  - Option code;
  - Start date;
  - Termination date;
  - Pap smear screening risk indicator, professional date, and technical date;
  - Mammography screening risk indicator (applicable to screening services prior to January 1, 1998), professional date, and technical date;
  - Colorectal screening (no risk indicator); procedure code, professional date, and technical date;
  - Pelvic screening risk indicator and professional date;
  - Pneumococcal pneumonia vaccine (PPV) date;
  - Influenza virus vaccine date; and
  - Hepatitis B vaccine date.

See Chapter 10 of this manual for a complete discussion of the HIQH (Health Insurance Query for Home Health Agencies).

The contractor will make sure that psychiatric information is not being made available to all hospitals. This information is to be made available **only** to psychiatric hospitals or hospitals that furnish inpatient psychiatric hospital services.

Providers may use direct entry terminals or dial-up terminals to inquire about beneficiary eligibility utilization and deductible status. The FI must use either the HIQA screen display (see §30.6.1.1) or create its own Customer Information Control System (CICS) screens from the HUQA data records (see §§30.6.1.2 and 30.6.1.3). Providers may not have access to any other CWF records, e.g., the health insurance master record (HIMR). The data must be from CWF. The FI will not substitute local history.

30.6.1 - Rules for Accessing Eligibility Data

(Rev. 1, 10-01-03)

A3-3508.1, B3-6100.1

The following rules apply to access of eligibility data:

- The capability to access data electronically is available to providers;
- Providers are responsible for their line costs;
- Access of eligibility data is used only for submitting a complete and accurate claim and is not to be disclosed to anyone that is not responsible for submitting a claim. This information is not to be disclosed to hospital-based physicians or to any health care provider that is not Medicare certified as defined in §1816 and §1866(e) of the Act.
- Pertinent technical details providers need to access this, including the minimum data required to identify the beneficiary is:
    - HICN;
    - Surname;
    - First initial;
    - Date of birth (CCYYMMDD); and
    - Sex code;
- Data the provider includes in the patient ID field in the incoming record will be returned to the provider in the return record. This data will not be edited by Medicare but will be returned to assist the provider in matching records. At a minimum, the provider must enter surname, HICN, and sex correctly to obtain a match;
- Screen data sets and presentations may vary, depending on the shared system providing them. The provider must identify itself for access;
- Data may not be perused, i.e. no data will be released except on a beneficiary-specific basis. Browsing is prohibited. A provider may send up to 99 names at a time to be verified;
- Eligibility data is available only to certified Part A Medicare Providers and participating physicians and suppliers that bill electronically using the National Standard Format (NSF) or the ANSI X12N 837 Health Care Claim Transaction Set;

- Access will be available to the provider on a “toll” basis; that is, the provider will incur all wire charges;

- The eligibility data is good only for the time the provider is receiving it. This information could change at any time, and does not guarantee Medicare coverage or payment; Medicare Part B and HMO enrollment and termination dates are the most recent available;

- Services must be rendered independent of the data in accordance with State and local laws regarding access to care;

- The provider must develop for MSP regardless of what the record shows;

- Data does not represent definitive eligibility status. If the individual is not on file, the provider must use the usual admission and billing procedures in effect independent of this data access; and

- Medicare eligibility information is confidential, and penalties available under the Privacy Act for illegal disclosure are being found guilty of a misdemeanor and being fined not more than $5,000.

30.6.1.1 - Part A Inquiry (HIQA) Screen Display

(Rev. 1, 10-01-03)

A3-3508.3

This screen is described in the CWF Documentation, Chapter VII, Section H, pages 1 through 7. All the data elements are explained in full for proper use. Contractors should access this screen to transmit data to their providers and suppliers when supplying data for §30.6.1.2.

30.6.1.2 - Part A Inquiry Reply (HIQAR) Screen Display

(Rev. 1, 10-01-03)

A3-3508.4

This screen format can be used to pass beneficiary entitlement and utilization data to the provider. It is described in the CWF Documentation, Chapter VII, Section H, pages 1 through 24. Refer to the CWF Documentation when providing utilization data to the provider.

30.6.1.3 - Part A Inquiry (HUQA) Data

(Rev. 1, 10-01-03)

A3-3508.5

This transaction may be used to obtain the HUQA dataset. (See §30.6.) Also, refer to Chapter II of the CSC maintained CWF Documentation.

30.6.1.4 - Part A Inquiry Reply (HUQAR) Data

(Rev. 1, 10-01-03)

A3-3508.6

This response can be used to create the contractor's own screens to return beneficiary eligibility and utilization data to providers. See Chapter II of the CSC maintained CWF Documentation.

30.6.1.5 - Health Insurance Query for Home Health Agencies (HIQH)

(Rev. 1, 10-01-03)

HHA 467.6

This transaction, which is available through RHHI remote access, is used by HHAs to ascertain whether an episode has been opened for a given beneficiary by another provider (who is the primary HHA) and to track episodes for beneficiaries for whom the inquiring HHA is the primary HHA. See Chapter II of the CSC maintained CWF Documentation.

30.6.2 - Carrier Implementation

(Rev. 1, 10-01-03)

B3-6100.2

The carrier will create a beneficiary identification file, with the HICNs of all of its Medicare beneficiaries within the last year, to be used to extract CWF HIQB data from the carrier's host. The carrier's CWF host will then provide an initial extract file of eligibility data based on the HICN match. The extract file will house only the required eligibility information. The carrier will use this file to pass eligibility data to its providers.

Every 24 hours, the carrier's host(s) will send it an extract file of updated transactions since the last transmission. The carrier should contact its CWF host site for details regarding this update. The carrier will apply the updated transactions to its extract file. Newly accreted beneficiaries or any beneficiary for whom the carrier has received a claim for the first time will **not** result in CWF sending a response with Part B eligibility

data to the carrier. If the carrier wants the data, it must submit an extract request. The carrier may initiate this when it receives the first claim or the carrier can wait until the provider requests data. Every 18 months, the carrier sends a file of deletions to be purged from the carrier's eligibility file to the carrier's host so that file sizes can be maintained. The carrier will return inquiries against its in-house extract file as soon as possible, given available computer capacity, but not later than 24 hours after it receives an inquiry.

An out-of-service area inquiry will be sent directly to the carrier's CWF host. The host response is then rerouted back to the carrier, who returns the response to the provider within three days.

There are five responses to be returned to the provider. The codes conform to ANSI X12N standards and are specified in the Beneficiary Detail Response Record. They are:

- Definitive reply;
- Still searching, will respond later;
- Invalid or missing HICN;
- Missing patient name; or
- Name with HICN not found.

CWF documentation provides detailed instructions regarding the carrier-CWF host interface.

30.6.3 - Data Format

(Rev. 1, 10-01-03)

B3-6100.3, AB-03-036

Contractors use one of the two CMS national standard flat file formats (one for professional claims, the other for institutional providers) to send and receive eligibility inquiries, or contractor's may use the ANSI X12N, 270 Health Care Eligibility/Benefit Inquiry Format which requires response with an X12N, 271 Health Care Eligibility/Benefit Information Transaction Set.

The provider may select whether to use a flat file format or X12N transaction. The X12N guidelines and formats are published on the CMS Internet EDI Web page at http://cms.hhs.gov/providers/edi/edi3.asp. A description of each flat file, both the file for professional claims and the file for institutional providers may also be linked to from the Medicare EDI Formats and Specifications Web page located at http://cms.hhs.gov/providers/edi/edi3.asp, under **Eligibility**, **Claim Status Request and Response**.

30.6.4 - Part B Eligibility Data Security Requirements

(Rev. 1, 10-01-03)

B3-6100.4

Eligibility information must be safeguarded, and unauthorized users must be identified and terminated from the system immediately. The contractor maintains a list of access violators for one year. The contractor's system must be able to automatically generate an exception report when:

- An unauthorized user tries to access the system. The carrier will disconnect after the first try;

- A nonparticipating provider tries to access the carrier's system. If a nonparticipating provider is detected trying to access the system, the nonparticipating provider is blocked from the eligibility access file. They may continue to conduct other legitimate business such as submitting claims and receiving remittance advice; and

- Claims-to-query ratio does not exceed 95 percent. Each quarter the carrier's system will compile a report that balances claims against inquiries. To give providers a chance to become familiar with their system, the claims-to-inquiry ratio will start at 90 percent, and will go up for the next three months until it reaches 95 percent. This means that for every 100 inquiries received, there must be 90 claims submitted the first month, ending with 95 claims submitted for every 100 inquiries after the 3-month phase-in period. If the claims-to-inquiry ratio does not exceed 95 percent from a given participating physician or supplier, that physician or supplier will receive an educational contact from the carrier. If there is a problem or the behavior continues, then the provider loses inquiry access.

30.6.5 - CMS Standard Part B Eligibility Inquiry Flat File Specifications

(Rev. 1, 10-01-03)

B3-6100.5

The carrier must receive these data elements from its providers in this format. The carrier must be able to service any provider requesting access to this data in 30 days.

Each record should be terminated with a line feed character, or a line feed and carriage return character combination.

BENEFICIARY HEADER REQUEST RECORD

FLD NO	FIELD NAME	FLD PICT	FROM	THRU	REMARKS
1	Header Field	X(4)	1	4	Must be “ELIG.”
2	Carrier Number	9(5)	5	9	The Medicare assigned carrier number.
3	Provider ID	X(10)	10	19	Provider’s Medicare number (blank fill).
4	Submitter ID	X(10)	20	29	System ID of the provider, clearinghouse, or billing service submitting the request (blank fill).
5	Date & Time Stamp	9(12)	30	41	Day/Time provider transmits records. Julian Date (CCYYDDD), Time (HHMMS). The carrier enters the value “0” for the fifth position (S). Providers and vendors must complete the field in the standard format. The carrier should not edit this field, but pass whatever the provider submits in this field to field 3 in the response record.
6	Filler	X(4)	42	45	Blank fill.

BENEFICIARY DETAIL REQUEST RECORD

FLD NO	FIELD NAME	FLD PICT	FROM	THRU	REMARKS
1	Record type	X (1)	1	1	Must be "D." Identifies detail.
2	Patient ID	X(17)	2	18	Reserved for provider use; the carrier does not edit this field.
3	Provider ID	X(10)	19	28	Provider's Medicare number. (blank fill).
4	Submitter ID	X(10)	29	38	System ID of the provider, clearinghouse, or billing service submitting the request (blank fill).
5	Beneficiary HICN	X(12)	39	50	The carrier enters the beneficiary's HICN (blank fill).
6	Beneficiary's Last Name	X(6)	51	56	First 6 characters of the beneficiary's last name (blank fill).
7	Beneficiary's First Initial	X(1)	57	57	First character of beneficiary's first name.
8	Gender	X(1)	58	58	F=Female, M=Male.

BENEFICIARY TRAILER REQUEST RECORD

FLD NO	FIELD NAME	FLD PICT	FROM	THRU	REMARKS
1	Total Detail Records	9(2)	1	2	Total number of detail records being sent with this request file (minimum of 1, maximum of 99.)

If the eligibility of more than one beneficiary is requested in a single transmission, the second detail request will start immediately after the first detail request. One transmission may contain up to 99 detail requests.

30.6.6 - CMS Standard Part B Eligibility Response Flat File Specifications

(Rev. 1, 10-01-03)

B3-6100.6

The carrier will transmit these data elements to its providers in this format. It will not impose these specifications on new users.

Each record should be terminated with a line feeder.

BENEFICIARY HEADER RESPONSE RECORD

FLD NO	FIELD NAME	FLD PICT	FROM	THRU	REMARKS
1	Header Field	X(4)	1	4	Must be "RESP." Signifies the beginning of the response file.
2	Carrier Number	9(5)	5	9	Medicare assigned carrier number.
3	Date & Time Stamp	9(12)	10	21	Date/time provider transmits records. Julian date (CCYYDDD). Time (HHMMS). The value "0" is entered for the fifth position (S).
4	Filler	X(24)	22	45	Reserved for future use.

BENEFICIARY DETAIL RESPONSE RECORD

FLD NO	FIELD NAME	FLD PICT	FROM	THRU	REMARKS
1	Header Field	X(1)	1	1	Must be "R." Indicates a detail response record.
2	Patient ID	X(17)	2	18	Reserved for Provider use; the carrier will not edit this field.
3	Provider ID	X(10)	19	28	Provider's Medicare number (blank fill).
4	Submitter ID	X(10)	29	38	System ID of the provider, clearinghouse or billing service submitting the request (blank fill).

FLD NO	FIELD NAME	FLD PICT	FROM	THRU	REMARKS
5	Response Type	9(2)	39	40	The carrier codes this field as follows: 11=Response (This is a definitive reply; 00=Automatic response. (This is a definitive reply based on a prior request. It is an update to extract data previously sent.); 21=Still searching; will respond later; 64=Invalid or missing HICN; 65=Missing patient name (e.g., surname or first initial); 66=Missing or invalid gender; 67=Name with HICN not found; 99=Problem in system. Cannot process. Please recycle the request. (If inquiry recycles 3 times, the carrier informs the CWF that there is a problem.)
6	HICN	X(12)	41	52	Beneficiary's Medicare number (blank fill).
7	Last Name	X(6)	53	58	First 6 characters of beneficiary's last name (blank fill).
8	First Initial	X(1)	59	59	First character of the beneficiary's first name.
9	Gender	X(1)	60	60	F=Female, M=Male.
10	Medicare Part B Entitlement Date	9(6)	61	66	Beneficiary's entitlement date for Medicare Part B eligibility (MMDDYY).
11	Medicare Part B Termination Date	9(6)	67	72	Beneficiary's entitlement date for Medicare Part B termination. (MMDDYY).
12	Current Year Deductible	9(2)	73	74	Year for the current deductible (YY).

FLD NO	FIELD NAME	FLD PICT	FROM	THRU	REMARKS
13	Current Year Deductible Indicator	X(1)	75	75	If "Y," deductible is met, if "N," deductible not met.
14	Prior Year Deductible	9(2)	76	77	Year for the prior Year deductible (YY).
15	Prior Year Deductible Indicator	X(1)	78	78	If "Y," deductible is met, if "N," deductible not met.
16	HMO Name	X(25)	79	103	Current Name of HMO.
17	HMO Zip Code	9(5)	104	108	HMO ZIP code.
18	HMO Enrollment Date	9(6)	109	114	Most current HMO enrollment date available (MMDDYY).
19	HMO Termination Date	9(6)	115	120	Most current HMO termination date available, if applicable (MMDDYY).
20	HMO Code	X(1)	121	121	C=Cost, R=Risk, Space or (Blank)=Non-HMO.
21	MSP Activity	X(1)	122	122	D=Develop.
22	Change Code	X(1)	123	123	If yes, beneficiary name or number has been corrected and the correct information returned. Receiver must use their patient ID for matching.
23	Filler	X(7)	124	130	Reserved for future use.

BENEFICIARY TRAILER RESPONSE RECORD

FLD NO	FIELD NAME	FLD PICT	FROM	THRU	REMARKS
1	Total Detail Records	9(2)	1	2	Total number of detail records being sent with this request file. (Minimum of 1, maximum of 99).

NOTE: All dates in the format MMDDYY should default to a value of "000000" where there is no meaningful information in the field.

30.8 - Health Insurance Master Record (HIMR) Inquiry

(Rev. 1, 10-01-03)

A3-3510

For Medicare contractors only, the HIMR Inquiry System provides access to CWF data stored at the nine CWF hosts. HIMR inquiries display complete information for entitlement, utilization, and payment history for Medicare beneficiaries. CWF Satellite personnel may utilize the HIMR Inquiry System for claim resolution, adjustment processing, and medical review. It is also available to all CWF Hosts, CMS Central and Regional offices, and the CWF maintenance Contractor for investigation and problem determination. A selection menu (HIMR Main Menu) lists all available displays. For a complete discussion of the HIMR Inquiry System, see http://cms.csc.com/cwf/downloads/docs/pdfs/overhimr.pdf.

30.10 - Beneficiary Master Information

(Rev. 1, 10-01-03)

A3-3512

See http://cms.csc.com/cwf/downloads/docs/pdfs/overhimr.pdf.

30.11 - Medicare Secondary Payer (MSP) Information

(Rev. 1, 10-01-03)

A3-3513

See http://cms.csc.com/cwf/downloads/docs/pdfs/overhimr.pdf.

30.12 - Group Health Organization (GHO)

(Rev. 1, 10-01-03)

A3-3514

See http://cms.csc.com/cwf/downloads/docs/pdfs/overhimr.pdf.

30.13 - Hospice Enrollment

(Rev. 1, 10-01-03)

A3-3515

See http://cms.csc.com/cwf/downloads/docs/pdfs/overhimr.pdf.

30.14 - Surgery Information

(Rev. 1, 10-01-03)

A3-3516

See http://cms.csc.com/cwf/downloads/docs/pdfs/overhimr.pdf.

30.15 - End Stage Renal Disease (ESRD)

(Rev. 1, 10-01-03)

A3-3517

See http://cms.csc.com/cwf/downloads/docs/pdfs/overhimr.pdf.

30.16 - Beneficiary Cross-Reference

(Rev. 1, 10-01-03)

A3-3518

See http://cms.csc.com/cwf/downloads/docs/pdfs/overhimr.pdf.

30.17 - DMEPOS Certificate of Medical Necessity (CMN) Display

(Rev. 1, 10-01-03)

A3-3519

Full DMEPOS CMN displays are available. See http://cms.csc.com/cwf/downloads/docs/pdfs/overhimr.pdf.

30.18 - True Not In File (TNIF) Status

A3-3520

See http://cms.csc.com/cwf/downloads/docs/pdfs/overhimr.pdf.

30.19 - Claim History Information

(Rev. 1, 10-01-03)

A3-3521

See http://cms.csc.com/cwf/downloads/docs/pdfs/overhimr.pdf.

30.19.1 - Inpatient History Overview

(Rev. 1, 10-01-03)

A3-3521.1

See http://cms.csc.com/cwf/downloads/docs/pdfs/overhimr.pdf.

30.19.2 - Outpatient/HHA History Inquiries

(Rev. 1, 10-01-03)

A3-3521.2

See http://cms.csc.com/cwf/downloads/docs/pdfs/overhimr.pdf.

30.19.3 - Hospice History

(Rev. 1, 10-01-03)

A3-3521.3

See http://cms.csc.com/cwf/downloads/docs/pdfs/overhimr.pdf.

30.19.4 - Part B History

(Rev. 1, 10-01-03)

A3-3521.4

See http://cms.csc.com/cwf/downloads/docs/pdfs/overhimr.pdf.

30.20 - Archived History Information

(Rev. 1, 10-01-03)

A3-3522

See http://cms.csc.com/cwf/downloads/docs/pdfs/overhimr.pdf.

30.21 - Requesting Assistance in Resolving Problem Areas in the Inquiry/Inquiry Response Procedures

(Rev. 1, 10-01-03)

A3-3523, 3-6008

See §70.

30.21.1 - HMO-Related Master File Corrections

(Rev. 1, 10-01-03)

A3-3523.1

The contractor will fully document and send to the HMO inquiries concerning problems with HMO data on the HI Master. The HMO will resolve the problem and advise the contractor of the results.

30.22 - Provider Problems Obtaining Entitlement Information

(Rev. 1, 10-01-03)

HO-300

If after application of the above procedures, the provider encounters significant problems in obtaining information regarding Medicare entitlement or benefits in order to accurately prepare bills, the provider should contact the contractor for assistance. However, these requests should be on a non-routine basis. The contractor will assist providers in obtaining entitlement information. The contractor may temporarily refuse assistance if a pattern of abuse is discovered. Situations that may require contractor assistance are:

- When the patient dies following admission. It may be necessary to file timely with an estate;
- When the patient is not in a physical or mental condition to discuss his/her entitlement, and no other person with knowledge of the patient's affairs is available;
- When the provider has reason to believe the beneficiary may need lifetime reserve days, and his/her signature must be obtained if the available lifetime reserve days are not to be used for this admission and other financial arrangements must be made;
- When it is suspected that the beneficiary may have exhausted his/her Medicare benefits, and timely confirmation is needed in order to file for possible supplemental benefits; and

- When the patient has experienced repeated admissions during the same spell of illness, and determining available benefits for the beneficiary is difficult.

50 - Critical Case Procedures - Establishing Entitlement Under Part A and B

(Rev. 1, 10-01-03)

See Chapter 27.

60 - Provider Contacts with the Social Security Office (SSO) to Obtain the HICN

(Rev. 1, 10-01-03)

HO-306

When a beneficiary cannot furnish the HICN, the provider requests the HICN from the SSO. The provider will establish a working procedure with the SSO for obtaining HICNs. The statement the provider obtains in accordance with Chapter 1 is authorization for the SSO to release the beneficiary's HICN to the provider. In the request, the provider advises the SSO that the statement is on file.

NOTE: The SSO will also help a beneficiary replace a lost or destroyed health insurance card.

60.1 - Information Required by the Social Security Office

(Rev. 1, 10-01-03)

HO-306.1

If the patient's social security number is available, the SSO usually requires no additional information to locate the HICN or to determine that the patient has not established HI entitlement.

If the social security number is not available, the provider furnishes the following information to the SSO:

- The patient's name and statement as to whether or not the patient ever applied for SS monthly benefits, RRB, or for HI benefits;

- If the patient states he/she has applied, the name of the person on whose SS number the application was based, e.g., his/her own, the number of a husband, or a wife;

- The full name of the patient's father, the maiden name of the mother, and the date and place of birth; and

- Patient's address.

If the provider cannot furnish all of the identifying information, it will furnish as much as possible.

60.2 - The SSO Reply

(Rev. 1, 10-01-03)

HO-306.2

The SSO will make every effort to furnish the HICN when available from SSO records within 24 hours (48 hours if more than one SSO is involved). When the requested information is not available, the office will supply an interim reply of the action it is taking, e.g., that the SSO requested a claim number from SSA central records, that the SSO is developing an application, or that an application is pending.

If an application for HI benefits is taken as a result of the provider's request for a claim number, or an HI application is pending, the SSO will give the claim number when processing is completed.

70 - SSO Assistance in Resolving Entitlement Status Problems

(Rev. 1, 10-01-03)

A - Social Security Office (SSO) Assistance

The contractor directs initial requests for assistance to the SSO if the problem is caused by difficulties in determining the beneficiary's correct entitlement status. Examples of situations that may require SSO assistance are:

- Problems involving Railroad Retirement Board (RRB) jurisdiction;

- Evidence that a beneficiary has utilization under more than one HICN but there is no awareness of any cross-reference action taken by CMS; or

- The beneficiary's name, address, sex code, date of birth, or date of death is incorrect on the HI master record.

In the event the SSO is unable to resolve the entitlement problem (e.g., cross referencing of HI records), the contractor requests assistance from the RO.

B - RRB Assistance

If the problem concerns an entitlement issue involving a claims number with an alpha prefix (A123456, WA12456789), the contractor sends requests for assistance via Form CMS-1980 to:

Railroad Retirement Board
Health Insurance Operations
844 Rush Street
Chicago, IL 60611

The RRB will investigate, initiate corrective action, and provide notification in the same manner as the SSO.

80 - Required Hospital Notice to Beneficiaries

(Rev. 1, 10-01-03)

HO-312

80.1 - Notice to Beneficiaries of QIO Review of Care

(Rev. 1, 10-01-03)

HO-312.A

Section 1866(a)(1)(M) of the Act (amended by §9305 of the Omnibus Budget Reconciliation Act of 1986) requires all hospitals (including hospitals paid under the PPS, and those waived or exempt from PPS) to provide Medicare beneficiaries (or the beneficiary's representative), at or about the time of the beneficiary's admission as an inpatient to the hospital, a written statement which explains:

- The beneficiary's right to benefits for inpatient hospital services and post-hospital services;
- The circumstances under which the beneficiary will or will not be liable for charges for continued stay in the hospital;
- The beneficiary's right to appeal denials of benefits for continued inpatient hospital services, including the practical steps to initiate such appeals; and
- The beneficiary's liability for payment for services if such a denial of benefits is upheld upon appeal.

Form CMS-R-193 must be used to do this. The form may be obtained at the CMS form page, http://www.cms.hhs.gov/forms/.

NOTE: Hospitals are not required to issue the message to patients who are transferred (or admitted) to swing beds (for skilled care or less than skilled care). A swing bed is not

considered a part of the hospital unit exempt from PPS. The message is designed to explain immediate review rights to the beneficiary (or his/her representative) in accordance with the provisions of the Omnibus Budget Reconciliation Acts of 1986 and 1987. Those provisions do not apply to continued stay notices of noncoverage involving transfers/admissions to swing beds.

Hospitals use the Spanish version of the message only to Spanish-speaking beneficiaries (or their representatives) who have difficulty understanding English.

Hospitals are not required, but are encouraged, to retain a signed copy of the notice in the beneficiary's medical records to substantiate compliance.

80.2 - Notice to Beneficiary of QIO Review of Need for Continued Hospitalization

(Rev. 1, 10-01-03)

HO-312.B

Section 4096(c) of the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203) requires providers to give a notice to patients when the provider and the patient's physicians disagree on the proposed notice, and the QIO is requested to review it. Providers may use their own letterhead, but they may not alter or change the language. They are required to give this notice to the beneficiary concurrently when giving the case to the QIO. Providers issue the following notice, "Notice to Beneficiary of PRO Review of Need for Continued Hospitalization."

Notice to Beneficiary of PRO Review of Need for Continued Hospitalization

(Name of Hospital) Hospital has determined that you no longer require an acute (hospital inpatient) level of care. Because your doctor disagreed with this decision by the hospital, the hospital is asking the Peer Review Organization (Name of PRO) to review your case.

(Name of PRO) will contact you to solicit your views about your case and the care you need.

You do not need to take any action until you hear from the Peer Review Organization.

_____

Medical Director

Chairperson, Utilization Review Committee, etc.

80.3 - QIO Monitoring of Hospital Admission Notice to Beneficiaries

(Rev. 1, 10-01-03)

HO-312.1

The QIO monitors hospitals on an ongoing basis to ensure that the hospitals are issuing the required notice to all beneficiaries. Corrective action is necessary when a QIO review indicates that:

- The message was not given to the beneficiary (or the beneficiary's representative);
- The message was given to the beneficiary (or the beneficiary's representative), but not at or about the time of admission (i.e., the message was given after the date of admission without appropriate justification);
- The content of the message has been altered; or
- The incorrect message was given to the beneficiary (or the beneficiary's representative), e.g., a Spanish-speaking beneficiary was given the English version of the message, or a beneficiary admitted to an exempt psychiatric unit (or the beneficiary's representative) was given the message applicable to PPS hospitals.

NOTE: Hospitals may use their own letterheads and color-coded paper to differentiate the various messages, but may not alter the language of the message, including the acknowledgment statement.

The hospital must insert the name, address, and telephone number of the QIO where indicated.

If the QIO determines that a hospital is not appropriately issuing the message, the QIO takes the following actions:

- The QIO notifies the hospital that the hospital must correct the problem immediately, and informs the hospital of any other interventions to be taken, e.g., intensification of review or resubmittal of a new distribution plan;
- Review of the message is intensified when five percent, or six inappropriate cases (whichever is greater), are found. Errors are computed on a quarterly basis. If error rate reaches or exceeds the threshold for a quarter, review will be intensified the next quarter. (Review may return to the non-intensified review level when the error rate falls below the threshold after a quarter's review); and
- If the problem continues, i.e., three consecutive quarters or a pattern of noncompliance is established, the QIO will refer the case to the Associate

Regional Administrator, Division of Health Standards and Quality, CMS, to consider termination of the provider agreement under §1866(b) of the Act.

90 - Outpatient Hospital Registration Procedures

(Rev. 1, 10-01-03)

HO-350

90.1 - Patient Identification

(Rev. 1, 10-01-03)

HO-350.A

Upon registration of a Medicare beneficiary, or as soon thereafter as practical, the hospital will ask the patient for his/her health insurance card to obtain the HICN. If the patient is unable to provide it, the hospital will contact the SSO for assistance.

90.2 - Determining Whom to Bill

(Rev. 1, 10-01-03)

HO-350.B

The procedures for determining whether another payer exists are the same for outpatient situations as for inpatient. Therefore, the hospital will follow §20 for developing other coverage.

90.3 - Source of Admission - Outpatient Hospital

(Rev. 1, 10-01-03)

HO-350.C

The hospital's registration process must distinguish whether the referral source for this registration/admission is from:

- Its own inpatient hospital;
- An encounter in another hospital (see §90.6 for definition of encounter); or
- Any other source - See Chapter 25.

Hospitals must determine the appropriate source of admission from internal records or by asking the patient who referred him/her, and whether the referral took place as a result of an encounter in the servicing hospital, another hospital, or elsewhere.

The following coding must be used on the outpatient claim. Therefore admission/registration processes must obtain the information.

1. Physician Referral - The patient was referred to this facility for outpatient or referenced diagnostic services by his/her personal physician, or the patient independently requested outpatient services (self-referral).

2. Clinic Referral - The patient was referred to this facility for outpatient or referenced diagnostic services by this facility's clinic or other outpatient department physician.

3. HMO Referral - The patient was referred to this facility for outpatient or referenced diagnostic services by an HMO physician.

4. Transfer from a Hospital - The patient was referred to this facility for outpatient or referenced diagnostic services by a physician of another acute care facility.

5. Transfer from a SNF - The patient was referred to this facility for outpatient or referenced diagnostic services by a physician of the SNF where the patient is an inpatient.

6. Transfer from Another Health Care Facility - The patient was referred to this facility for outpatient or referenced diagnostic services by a physician of another health care facility where the patient is an inpatient.

7. Emergency Room - The patient was referred to this facility for outpatient or referenced diagnostic services **by** this facility's emergency room physician.

8. Court/Law Enforcement -The patient was referred to this facility for outpatient or referenced diagnostic services upon the direction of a court of law, or upon the request of a law enforcement agency representative.

9. Information not available.

10. Transfer from a CAH - The patient was referred to this facility for outpatient or referenced diagnostic services by (a physician of) the CAH were the patient is an inpatient.

The hospital must determine the proper source of admission code based on the patient's response and/or any other information the hospital may have available from its preregistration records or scheduling data. The hospital must enter the proper source of admission code in item 18 of Form CMS-1450, also known as the UB-92.

If the patient was referred for services by a physician at:

- This hospital, the hospital enters codes 2 or 7;

- Another hospital, the hospital enters code 4; or

- Some other source, the hospital enters codes 1, 3, 5, 6, 8, 9, or A, as appropriate.

If the hospital is sure the admission source is not from its hospital or another hospital but cannot determine which of the codes apply, the hospital will enter code 1 on Medicare claims. However, incorrect reporting where services were referred by staff at its own hospital or another hospital (codes 2, 4, or 7 are applicable) is considered program abuse and subject to applicable sanctions.

90.4 - Type of Bill

(Rev. 1, 10-01-03)

HO-350.D

To bill properly, the provider assigns a type of bill based on whether:

- Services are for referred diagnostic tests ordered by a source other than a clinic, emergency room, or other outpatient department physician at the servicing facility. For example, if the patient is seen by a physician in the physician's office and is referred for a diagnostic test the bill type will be a 14X; or

- Services are related to consultation or therapy managed by professional staff in the servicing hospital's emergency room, clinic or other outpatient are as a result of an encounter in that hospital. This may include diagnostic tests. For example, if the patient is seen by a physician at the hospital's clinic for consultation and diagnostic testing, the bill type will be a 13X.

90.5 - Definition of Diagnostic Services

(Rev. 1, 10-01-03)

HO-350.E

A service is "diagnostic" if it is an examination or procedure to which the patient is subjected, or which is performed on materials derived from a hospital outpatient to obtain information to aid in the assessment of a medical condition or the identification of a disease. Among these examinations and tests are diagnostic laboratory services such as hematology and chemistry, diagnostic x-rays, isotope studies, EKGs, pulmonary function tests, psychological tests, and other tests given to determine the nature and severity of an ailment or injury. Hospitals may determine whether services are diagnostic from their internal systems as appropriate.

90.6 - Definition of Encounter

(Rev. 1, 10-01-03)

HO-350F

The term “encounter” means a direct personal contact in the hospital between a patient and a physician, or other person who is authorized by State law and, if applicable, by hospital staff bylaws to order or furnish services for diagnosis or treatment of the patient. Direct personal contact does not include telephone contacts between a patient and physician. Nor is the compensation arrangement between the physician and the hospital relevant to whether an encounter has occurred. Patients will be treated as hospital outpatients for purposes of billing for certain diagnostic services that are ordered during or as a result of an encounter that occurred while such patients are in an outpatient status at the hospital. If a Medicare outpatient is referred to another provider or supplier for further diagnostic testing or other diagnostic services as a result of an encounter that occurs in this hospital, the hospital is responsible for arranging with the other entity for the furnishing of services. Hospitals are not required to verify that all ordered services are furnished but only to assure that, when it is necessary to refer a patient to an outside entity, the referral is made to a provider or supplier with which the referring hospital an arrangement. This requirement is necessary to assure that billing for services that are furnished is processed through the servicing hospital.

When a patient has follow-up visits with a physician in the hospital following an initial encounter, each subsequent visit to the physician will be treated as a separate encounter for billing.

100 - Hospice Notice of Election

(Rev. 1, 10-01-03)

See chapter 11 for instructions for completing the hospice election.

100.1 - FI Reply to Notice of Election

(Rev. 1, 10-01-03)

HSP - 302.2

The reply to the notice of election is furnished according to hospice arrangements with the FI. Whether the reply is given by telephone, mail, or wire, it is based upon the FI’s query to CMS master beneficiary records, and it contains the necessary Medicare Part A eligibility information.

110 - ESRD Method Selection

(Rev. 1, 10-01-03)

See Chapter 8 for instructions for completing the ESRD Method Selection Form.

110.1 - ESRD Method of Selection Transaction to Common Working File (CWF) and Response

(Rev. 1, 10-01-03)

See CWF documentation at http://cms.csc.com/cwf/default.htm.

120 - Religious Nonmedical Health Care Institution (RNHCI) Admission

(Rev. 1, 10-01-03)

120.1 - Election Requirements

(Rev. 1, 10-01-03)

PM AB-00-30.60

See Chapter 5 of the General Information, Eligibility, and Entitlement Manual for a description of RNHCI provisions.

The RNHCI benefit provides only for Part A inpatient services. For an RNHCI to receive payment under the Medicare program, the beneficiary must make a written election to receive benefits under §1821 of the Act. To elect religious nonmedical health care services, the beneficiary or the beneficiary's legal representative must attest that the individual is conscientiously opposed to acceptance of nonexcepted medical treatment, and the individual's acceptance of such treatment would be inconsistent with the individual's sincere religious beliefs. The signed and notarized election must include a statement that the receipt of nonexcepted medical services would constitute a revocation of the election and may limit further receipt of payment of religious nonmedical health care services. The election is effective on the date it is signed, and it remains in effect until revoked in writing or by the receipt and filing a claim for nonexcepted medical treatment. The completed election form must be filed with the specialty FI and a copy retained by the RNHCI provider. Section 1821 defines "excepted" medical treatment as medical care or treatment that is received involuntarily or is required under Federal, State or local law. "Nonexcepted" medical treatment is defined as medical care or treatment other than excepted medical treatment.

The RNHCI provider should question each beneficiary prior to executing the election statement to determine if the beneficiary has Medicare Part B coverage in effect via a

health plan or has recently received care for which Medicare payment was sought. An affirmative answer will alert the RNHCI provider that the claim may be denied.

120.2 - Revocation of Election

(Rev. 1, 10-01-03)

PM AB-00-30.60

See Chapter 5 of the General Information, Eligibility, and Entitlement Manual.

Under §1821(b)(3), a beneficiary may revoke an election in writing or by receiving nonexcepted medical care. After an initial revocation, the individual may again file a written election to receive the religious nonmedical health care benefit. This second election takes effect immediately upon its execution. If an individual makes and revokes a second election, the third election may not become effective until the date that is one year after the date of the most previous revocation. Any subsequent election may not become effective until the date that is five years after the date of the most recent previous election. Once an election has been revoked, Medicare payment cannot be made to an RNHCI unless a new valid election is filed. The RNHCI revocation does not interfere with the beneficiary's ability to seek other Medicare services within the limits of his/her Medicare coverage.

120.3 - Completion of the Uniform (Institutional Provider) Bill (Form CMS-1450) Notice of Election for RNHCI

(Rev. 1, 10-01-03)

PM AB-00-30.60

This form, also known as the UB-92, was developed to be suitable for submitting claims to most third party payers (both Government and private). Because it serves the needs of many payers, a particular payer may not need some data elements. Detailed information is given only for items required for the notice of election. Items not listed need not be completed, although the RNHCI may complete them when billing multiple payers.

Form Locator (FL) 1 or RT 10, Fields 12, 13, 14, 15 and 16 (Untitled) - Provider Name, Address, and Telephone Number

Required - The minimum entry is the RNHCI's name, city, State, and ZIP code. The post office box number or street name and number may be included. The State may be abbreviated using standard post office abbreviations. Five- or 9-digit ZIP codes are acceptable. The RNHCI uses the information to reconcile provider number discrepancies. Phone and/or FAX numbers are desirable.

FL 4 or RT 40, Field 04 - Type of Bill

Required - The RNHCI enters the 3-digit numeric type of bill code: 41A, 41B, or 41D as appropriate. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular episode of care. It is referred to as a "frequency" code.

Code Structure

1st Digit - Type of Facility

4- RNHCI (hospital)

2nd Digit - Classification (Special Facility)

1- Inpatient (Part A)

3rd Digit - Frequency

A - RNHCI election notice

B - RNHCI revocation notice

D - Cancellation

FL 12 or RT 20, Fields 4-6 - Patient's Name

Required - The RNHCI enters the patient's name with the surname first, first name, and middle initial, if any.

FL 13 or RT 20, Fields 12-16 - Patient's Address

Required - The RNHCI enters the patient's full mailing address including street name and number, post office box number or RFD, city, State, and ZIP code.

FL 14 or RT 20, Field 8 - Patient's Birth Date

Required - (If available.) The RNHCI enters the month, day, and year of birth numerically as MMDDCCYY. If the date of birth cannot be obtained after a reasonable effort, the field will be zero-filled.

FL 15 or RT 20, Field 7 - Patient's Sex

Required - The RNHCI enters an "M" for male or an "F" for female.

FL 17 or RT 20, Field 17 - Admission Date

Required - The RNHCI enters the date of the election, revocation or cancellation. In no instance should the date be prior to July 1, 2000. Show the month, day, and year numerically as CCYYMMDD.

FLs 51 A, B, and C or RT 10, Field 6 - Provider Number

Required - This is the 6-digit number assigned by Medicare. It must be entered on the same line as "Medicare" in FL 50.

FLs 58A, B, C, or RT 30, Fields 12-14 - Insured's Name

Required - The RNHCI enters the beneficiary's name on line A if Medicare is the primary payer. The RNHCI enters the name as on the beneficiary's HI card. If Medicare is the secondary payer, the RNHCI enters the beneficiary's name on line B or C, as applicable, and enters the insured's name on line A.

FLs 60A, B, C, RT 74, Field 5 - Certificate/Social Security Number and Health Insurance Claim/Identification Number

Required - On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information is shown in FL 58, the RNHCI enters the patient's HICN. For example, if Medicare is the primary payer, it enters this information in FL 60A. The RNHCI enters the number as it appears on the patient's HI Card, Social Security Award Certificate, Utilization Notice, MSN, Temporary Eligibility Notice, etc., or as reported by the SSO.

FL 85-6. Provider Representative Signature and Date

Required - An RNHCI representative makes sure an original, signed RNHCI election statement has been sent to the specialty contractor and the RNHCI has retained a copy in its records before signing Form CMS-1450. A stamped signature is acceptable on Form CMS-1450.

120.4 - Common Working File (CWF)

PM AB-00-30

A. CWF Notification of Elections

RNHCIs submit the signed election form to the specialty contractor (Blue Cross and Blue Shield of Tennessee) for RNHCI providers for elections on or after July 1, 2000. RNHCIs utilizing the hard copy UB-92 (Form CMS-1450) use bill type 41A as an election notice. Such RNHCIs complete FLs 1, 4, 12, 13, 14, 15, 17, 51, 58, 60, and 85 (refer to §120.3). RNHCIs utilizing the UB-92 flat file as an election notice use Record Types (RT) 10, 20, 30, 40, and 74. See §120.3 below for the appropriate fields. CWF

will transmit a disposition 01 to notify the specialty contractor that the notification of election was received.

B. CWF Notification of Revocations

RNHCIs submit a Form CMS-1450 (bill type 41B) to the specialty contractor as a notice of revocation for a previously posted RNHCI election when an RNHCI beneficiary submits a written request that his/her election of RNHCI benefits be revoked. See Subsection D, "CWF Actions," below for situations where RNHCI elections are automatically revoked in CWF. CWF will transmit a disposition 01 to notify the specialty contractor that the notification of revocation was received.

C. CWF Notification of Cancellations to Notifications of Elections and Revocations

RNHCIs submit a Form CMS-1450 (bill type 41D) to the specialty contractor as a cancellation of a previously submitted notice of election or notice of revocation, when they were submitted in error. In situations where the RNHCI is correcting a previously submitted date, they submit a new Form CMS-1450 (bill type 41A) to the specialty contractor for processing. CWF will transmit a disposition 01 to notify the specialty contractor that the notification of cancellation was received.

D. CWF Actions

CWF maintains a beneficiary file of all RNHCI beneficiary elections and revocations. CWF rejects claims as follows:

- Any notices of revocations or cancellations when CWF history indicates an RNHCI claim has been processed during this time period;

- FI claims (Form CMS-1450's, non 41X) with dates of service on or after July 1, 2000, when a beneficiary who has elected care under the RNHCI benefit received care outside the RNHCI;

- Carrier claims (Form CMS-1500's) that are submitted by physicians or ambulance companies with dates of service on or after July 1, 2000, when a beneficiary who has elected care under the RNHCI benefit received care outside of the RNHCI. These claims will be rejected by the contractor with an "08" trailer code describing the error. Note that these claims must be medically reviewed to determine if the care received by the RNHCI beneficiary was excepted or nonexcepted. Examples of nonexcepted medical care could include but are not limited to the following:

    - A beneficiary receiving medical diagnosis and/or treatment for persistent headaches and/or chest pains.

    - A beneficiary in an RNHCI who is transferring to a community hospital to have radiological studies and the reduction of a fracture.

- A beneficiary with intractable back pain receiving medical, surgical, or chiropractic services.

Examples of excepted medical care include, but are not limited to the following:

- A beneficiary that receives vaccinations required by a State or local jurisdiction. This is compliant behavior to meet government requirements and not considered as voluntarily seeking medical care or services; or

- A beneficiary who is involved in an accident and receives medical attention at the accident scene, in transport to the hospital, or at the hospital before being able to make his/her beliefs and wishes known; or

- A beneficiary who is unconscious, receives emergency care, and is hospitalized before regaining consciousness or being able to locate his or her legal representative.

Determinations must be made within 30 days of the receipt of the "08" trailer code. Once the determination is made, the claim is resubmitted to CWF indicating what type of care was received and using the following indicators for this purpose:

- Indicator "0" - no entry;
- Indicator "1" - for excepted care; or
- Indicator "2" - for nonexcepted care.

The following are the fields and locations for the excepted and nonexcepted indicators on the CWF record types:

Record	**Location**	**Field**	**Size**
HUIP	84	1	823
(IP hospital/SNF Claim)			
HUOP	64	1	778
(Outpatient)			
HUHC	64	1	778
(Hospice)			
HUHH	64	1	778
(Home Health)			
HUBC	13	1	57
(Carrier/Part B Claim)			

Upon receipt of the resubmitted claim, CWF will approve it for payment (by generating a disposition "01") and revoke the beneficiary's election if the care received was nonexcepted. CWF will **not** notify the specialty contractor of any revocations as a result of claims received for nonexcepted care. Any subsequent RNHCI claims will be not approved for payment by CWF unless the beneficiary files a new election following the prescribed time intervals between elections.