CMS Manual System

Pub. 100-04 Medicare Claims Processing

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

Transmittal 133 **Date: APRIL 2, 2004**

CHANGE REQUEST 3115

I. SUMMARY OF CHANGES: Billing non-covered charges to fiscal intermediaries – summary and new instructions – Clarification to Change Request 2634, Transmittal 25 to claims processing, dated October 31, 2003.

REVISED MATERIAL - EFFECTIVE DATE: April 5, 2004.

IMPLEMENTATION DATE: April 16, 2004.

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

II. SCHEDULE OF CHANGES:
(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	1/60.1/General Information on Noncovered Charges
R	1/60.1.1/Notification Requirements Related to Noncovered Charges Prior to Billing
R	1/60.1.2/Services Excluded by Statute
R	1/60.1.3/Claims with Condition Code 21
R	1/60.1.4/Summary of All Types of No Payment Claims
R	1/60.1.5/General Operational Information on Noncovered Charges
R	1/60.2/Noncovered Charges on Inpatient Bills
R	1/60.3.1/Traditional Demand Bills (Condition Code 20)
R	1/60.3.2/General Demand Billing Instructions, Inpatient and Outpatient (Other than HH PPS and Part A SNF)
R	1/60.3.3/Summary of Methods for Demand Billing
R	1/60.4/Noncovered Charges on Outpatient Bills
R	1/60.4.1/Billing With an ABN (Use of Occurrence Code 32) Comparable to Traditional Demand Bills
R	1/60.4.2/Line-Item Modifiers Related to Reporting of Noncovered Charges When Covered and Noncovered Services Are on the Same Claim
R	1/60.4.3/Clarifying 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/New Instructions for Noncovered Charges for Mileage on Ambulance

	Claims
R	1/60.4.5/Clarification of Liability for Preventive Screening Benefits Subject to Frequency Limits
R	6/40.6.4/Bills with Covered and Noncovered Days
R	6/40.6.5/Notification on Limitation of Liability Decisions
R	6/40.7/Other Billing Situations

III. FUNDING: *Medicare contractors only:

These instructions should be implemented within your current operating budget.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Special Notification

Attachment - Business Requirements

Pub. 100-04	Transmittal: 133	Date:April 2, 2004	Change Request: 3115

SUBJECT: Billing NonCovered Charges to Fiscal Intermediaries – Summary and New Instructions - *Clarification*

I. GENERAL INFORMATION

NOTE: This change request (CR) is a clarification to previous business requirements for CR 2634, Transmittal 25. The changes in this clarification were required both by insurmountable limits found in Medicare claims processing systems while programming CR 2634 after its publication, by new, non-systems instructions in the Advance Beneficiary Notice (ABN) area, and by confirmation of policy regarding ambulance charges receiving a subsidy. Therefore, **NO** Medicare systems changes are required, since the instruction is being revised to fit the systems as currently being programmed. A crosswalk of changes made in the CR 2634 requirements is attached.

A. Background: This instruction summarizes existing instructions related to the billing of noncovered charges by providers submitting fee-for-service claims to Medicare fiscal intermediaries (FIs) or regional home health intermediaries (RHHIs). **Since noncovered charges can only be billed on claims, the scope of this instruction is limited to claims, not other transactions using the claim format (i.e., requests for anticipated payment (RAPs), notices of election (NOEs)).** While inpatient facilities have been able to bill noncovered charges for some time, Medicare systems have only had end-to-end capacity to process non-covered charges for outpatient providers on claims with other covered charges as of April 2002. **Though primarily a non-systems clarification to a previous CR (CR 2634, Transmittal 25), this document does provide limited new instructions for billing in relation to ABNs, particularly for skilled nursing facilities (SNFs)**. Instructions on ABN*s* can be found in Chapter 30 of the Medicare Claims Processing Manual (Pub. 100-04). Additionally, changes in policy for billing ambulance charges where a subsidy is involved or a beneficiary has died have been updated in the package.

B. Policy: This instruction supplements previous Transmittal 25. 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: The CMS shall notify providers if a "medlearn matters" article is prepared and available at www.cms.hhs.gov/medlearn/matters on this instruction via the "medlearn matters" listserv. If so, intermediaries shall post this article, or a direct link to this article, on their website and include

information about it in a listserv message within one week of the availability of the provider education article. Education may only be thought necessary on the new portion of the instruction relative to ABNs and ambulance charges **as per the specific requirements below**, since otherwise this is a clarification to a previous instruction for which many FIs have already recently performed education. Intermediaries may publish information in their next regularly scheduled bulletin. If they have a listserv that targets affected providers, they may use it to notify subscribers that information in this clarification instruction is available on their Web site.

II. BUSINESS REQUIREMENTS

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

Requirement #	Requirements	Responsibility
3115.1	FIs shall be aware of changes made in the business requirements of CR 2634 as a result of FISS systems walkthroughs on that instruction, and educate providers if warranted (revised CR 2634 requirements highlighting all changes are attached as Attachment C, which is contained in this Word document, and all other attachments, though separate Word files, are also updated to reflect the walkthroughs).	FIs
3115.2	FIs shall educate hospitals and SNFs, when they believe warranted, as to the new option for billing in association with the SNFABN when custodial care or termination of the benefit is involved (this billing option is effective with the implementation date of this CR), and other billing updates related to the currently voluntary SNFABN. [These changes are described in attachments to this transmittal, see in particular the Chapter 6 attachment, pointing to existing text in the Medicare Claims Processing Manual, Chapter 30, Sections 70 and 80; however, other changes may occur to SNFABN policy, in the period subsequent to the 3/16/04 Town Hall Meeting on this topic and expected formalization of the currently voluntary SNFABN form in late 2004.]	FIs
3115.3	FIs shall educate providers as to the correct billing procedures for submitting ambulance mileage charges on their claims when subsidies are involved, and in the cases where a beneficiary dies during transport, when FIs believe such training is warranted (billing options presented in this package are effective with the implementation date of this CR). [These changes are described in attachments to this transmittal, see in particular the Chapter 1 attachment, §	FIs

	60.4.4, and Attachment B, §III, I—these contain two versions of the same text.]	

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

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: CR 3077, on home health claims, makes use of no payment codes, and supports part of the manualizations and educational documents attached to CR 2634. However, the business requirements of CR 2634, and this clarification to CR 2634, CR 3115, do not overlap the business requirements, systems changes or manualizations attached to CR 3077.

F. Testing Considerations: N/A

IV. OTHER CHANGES

Citation	Change

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: April 5, 2004 (for claims affected by CR 2634; this CR is a non-systems clarification to CR 2634). **Implementation Date:** April 16, 2004. **Pre-Implementation Contact(s):** Elizabeth Carmody, (410) 786-7533, or Cindy Murphy (410) 786-5733 **Post-Implementation Contact(s):** Appropriate regional office	**These instructions should be implemented within your current operating budget.**

3 Attachments

ATTACHMENT A

Definition of Fee-for-Service (Traditional or Original) Medicare Inpatient and Outpatient Services by Bill Type

Concise/General Policy Description: ***An inpatient service*** requires a beneficiary reside in a specific institutional setting during treatment. ***An outpatient service*** is provided by an institutional provider, but beneficiaries are not necessarily confined to a specific institution for periods of 24 hours or more.

Concise/General Claims/Systems Definition: The use of the category terminology is understood to reference the specific listed bill types, EXCEPT ***general use of the term outpatient is generally understood as all bill types EXCEPT those defined as inpatient Part A***. Specific trust fund payment is associated with these bill types. Note an "x" represents a varying third digit in the bill type not needed to identify the benefit.

Category	Medicare FFS Bill Types (All Types Listed)	Trust Fund Payment
Inpatient Part A	**11x** – Hospital **18x** – Swing Bed **21x** – Skilled Nursing Facility (SNF) **41x** – RNHCI – Religious Non-Medical Health Care Institution	Part A only
Inpatient Part B*	**12x** – Hospital **22x** – SNF	Part B only
In/Outpatient	**81x, 82x** – Hospice	Part A only

Part A*		
Outpatient*	**13x, 14x** – Hospital **23x** – SNF **34x –** Home Health (not prospective payment (PPS)) **71x** – RHC – Rural Health Clinic **72x** – RDF – Renal Dialysis Facility **73x** – FQHC – Federally Qualified Health Center **74x** – ORF – Outpatient Rehabilitation Facility **75x** – CORF – Comprehensive ORF **76x** – CMHC – Community Mental Health Center **83x** – Hospital Outpatient Surgery[1] **85x** – Critical Access Hospital (CAH) ========== =========== **32x, 33x** – Home Health (PPS) ========== =========== **89x** – NOE[2] for Coordinated Care Demonstration	Part B only ======= Parts A and B ======= No payment

* Treated as outpatient in processing unless instructions specify otherwise.

Note that for inpatient Part B claims, since 10/2003 HIPAA requires that, when transmitted, these claims conform to inpatient requirements for the institutional 837 claim transaction, though Medicare systems will still process these claims like outpatient transactions when received.

[1]Subject to Ambulatory Surgery Center (ASC) payment limits

[2] Notice of Election, which creates a benefit period in Medicare systems (Common Working File) against which utilization or payment can be tracked; this is the only type of NOE that requires a specific character in the second digit of the bill type, aside from requirements for the frequency cod (third digit).

ATTACHMENT B

Summary of Fiscal Intermediary Billing of Noncovered Charges

Purpose: This document summarizes existing instructions related to the billing of noncovered charges by providers submitting fee-for-service claims to fiscal intermediaries (FIs) or regional home health intermediaries (RHHIs). While inpatient facilities have been able to bill these charges for some time, Medicare systems have only had end-to-end capacity to process noncovered charges for outpatient providers on claims with other covered charges as of April 2002.

This document does provide some new instructions, but only to the extent that current instructions did not provide enough specificity on certain aspects of billing or failed to apply broad concepts to all bill types, especially in association with liability-related notices such as the advance beneficiary notice (ABN). New instructions or clarifications are noted as they arise, and citations are given for pertinent existing instructions that are not supplanted by this instruction. *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).*

Liability notices, such as the Part B ABN, **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 under §1862(a)(1) of the Act can relate to services not being reasonable and necessary, §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.*

I – Notification Requirements Related to Noncovered Charges – PRIOR to Billing

A. **Payment Liability Conditions of Billing [Table 1]**. 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 the Medicare Claims Processing Manual). 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. **With this instruction, such 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.*

This instruction focuses on issues of liability related to denials of charges submitted as noncovered. 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 Chapter 1 of the Medicare Claims Processing Manual, 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 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/medlearn/medicare.bni/*
- *Chapter 30 of the Medicare claims Processing 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 of the Act. 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, t*here *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 Sarrassat 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/
>
> **(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--** *including Part B SNF, HHA not under a plan of care, CORF and outpatient hospital***-- and hospice**

services ONLY *among FI-billed services*. *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
- **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, which will be discussed further below (III.A.and D. below).

B. Summary of Notices by Provider Type [Table 2]

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 form (i.e., CMS Form 10055 for SNF Part A)*	**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	No notice requirement	**All providers**

Liability Condition 3		

*** 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.**

II – Inpatient Billing – Noncovered Charges

No Payment Inpatient Hospital and SNF Claims. Where stays begin with a noncovered level of care and end with a covered level, only one claim is required for both the noncovered and covered period, which must be billed in keeping with other billing frequency guidance (i.e., SNFs are required to bill monthly). However, SNFs and inpatient hospitals are required to submit discharge bills in cases of no payment. These bills must correctly reflect *provider and beneficiary* liability *(see Chapter 6, §40.6.4)*. For SNFs, provider-liable no payment bills should be submitted **before** discharge in order to assure utilization chargeable periods are clearly posted. For inpatient hospital PPS claims that cannot be split *into covered and noncovered periods*, hospital providers can submit occurrence span code 77 for provider-liable noncovered periods, and occurrence span code 76 for beneficiary-liable noncovered periods.

These procedures must be followed for Part A inpatient services (**TOBs: 11x (hospital), 18x (swing bed), 21x (SNF), 41x (religious non-medical health care institutions—RNHCI)**), but are not required for inpatient Part B. These no payment bills contain:

- **All charges** submitted as **noncovered**;
- **Frequency code 0** (zero) to be used in the third position of the type of bill (TOB) form locator of the *original* claim *(i.e., not adjustment or cancellation)* [**NOTE**: If providers do not submit no payment claims with this frequency code, the standard systems *may* already act to change the frequency code to 0 *or return the claim to the provider*];
- **Total charges** equal the sum of noncovered charges; and
- **Basic required claim elements** must be completed.

Note units are not required when reporting noncovered days on SNF and Inpatient Rehabilitation claims using Health Insurance Prospective Payment Systems (HIPPS) codes. Claims that do not conform to these requirements will be returned to providers. **For SNF**, occurrence code 22 should **also** be used on no payment claims when SNF care is reduced to a noncovered level and benefits had previously been exhausted. This instruction is consistent with §40.7, Chapter 6 (Inpatient SNF) in the *Medicare Claims Processing Manual*.

Current instructions for inpatient no payment claims are found in the following locations:

- §40.7, Chapter 6 (Inpatient SNF), in the *Medicare Claims Processing Manual*;

- §40.4, Chapter 3 (Inpatient Hospital), in the *Medicare Claims Processing Manual*.

NOTE: Though discussed under Section III below on outpatient claims, inpatient claims may also be submitted using condition codes 20 and 21 in keeping with current billing practices. For example, a demand bill using condition code 20 may be used for SNF or hospital inpatient billing once a notice of non-coverage is provided. **Also, see III. D. 2. below for** *new and existing (SNF) and* **new** *(i.e., hospital)***inpatient demand billing instructions for hospitals.**

III – Outpatient Billing: Billing Noncovered Charges (TOBs other than 11x, 18x, 21x and 41x)

The term "outpatient" is used very generally in this instruction. From this point forward in this document, the term should be applied to benefits that are **both:** (1) **Not** exclusively inpatient, AND (2) **Not** Part A TOBs (i.e., **not** TOBs11x, 18x, 21x, 41x). Therefore, "outpatient" here includes inpatient Part B (TOBs 12x, 22x) and hospice (TOBs 81x, 82x)-- see Attachment A for a complete TOB list. Occasionally, inpatient claims are also discussed in this section, but they are specifically cited whenever guidance is also applicable to these bill types.

A. Services Excluded by Statute

Medicare will not pay for services excluded by statute, which often are services not recognized as part of a covered Medicare benefit. Examples of such services are given to beneficiaries in the "Medicare and You" handbook, at the end of the "Part A/Part B Cost and Coverage" subsection under Section 4 on the "Original Medicare Plan". Such services cannot necessarily be recognized in the definition of a specific procedure or diagnosis code. For example, under some conditions, a given code may be covered as part of a given benefit, but under other cases when no benefit is applied, the same code would not be covered. For claims submitted to FIs/RHHIs, these services may be: (1) Not submitted to Medicare at all, (2) Submitted as noncovered line items, or (3) Submitted on entirely noncovered claims.

1. Medicare does not require procedures excluded by statute *to* **be billed** *on institutional claims submitted to FIs/RHHIs* ***unless*****: (a) Established policy requires** either all services in a certain period, covered or noncovered, be billed together so that all such services can be bundled for payment consideration (i.e., procedures provided on the same day to beneficiaries under OPPS), or billing is required for reasons other than payment (i.e., utilization chargeable in inpatient settings); or **(b) A beneficiary requests** Medicare be billed in a manner that the service in question will be reviewed by Medicare (more on demand billing in III. D. below).

2. To submit a **noncovered line item** on a claim with other covered services (Payment Liability Conditions 1 and 3), use the modifier –GY on all line items for statutory exclusions. Submit all charges for those item(s) as noncovered charges, and otherwise complete the claim as is appropriate for the covered charges. More information is given on the –GY modifier (see III. G. below). **This option should only be used when providers are unable to split noncovered services onto a separate claim ((3) below).**

3. To submit statutory exclusions on **entirely noncovered claims** (Payment Liability Condition 1 only), use condition code 21, a claim-level code, signifying <u>all</u> charges that are submitted on that claim are noncovered charges. No

–GY modifiers need be attached to any of the procedure codes on such a claim, and **all charges must be submitted as noncovered** (see general billing requirements under Other Uses of No payment Claims with Condition Code 21, in III. B.2. below).

B. Other Uses of No Payment Claims with Condition Code 21

Condition code 21 can be employed to indicate no payment outpatient claims are being submitted for other reasons in addition to III. A. above:

At a beneficiary's, or other insurer's, request, to obtain a denial from Medicare on any kind of noncovered charges, to facilitate payment by subsequent insurers (e.g., statutory exclusions outside Medicare benefits, such as most self-administered drugs; no modifier is required to establish liability);
With an HHABN in special cases (see III. B. 1., immediately below);
With a SNFABN in special cases (see III. D.1. d. below).

1. **Custodial Care under HH PPS, or Termination of the Benefit during an Episode Period.** The use of no payment claims in association with an HHABN involving custodial care and termination of a benefit during an episode period are new clarifications of CMS policy. This clarification does not apply to cases in which a determination is being requested as to the beneficiary's homebound status at the beginning of an episode; there an ABN must be used if a triggering event occurs. However, in cases where the HH plan of care prescribes only custodial care, or if the benefit has terminated during an episode period, and the physician, beneficiary and provider are all in agreement the benefit has terminated or does not apply, home health agencies (HHAs) can use:

a. The HHABN for notification of the beneficiary, selecting Option A on that form; and

b. A condition code 21 no payment claim to bill all subsequent services.

NOTE: Providers can never pre-select ABN options for beneficiaries, in accordance with existing ABN policy. In each case, the beneficiary must *choose* the option they want to select. The ABN options presented relative to specific billing scenarios above, and in the rest of this document, are only illustrations and in no way authorization for pre-empting a beneficiary's right to choose a specific option.

Special instructions for HH PPS no payment claims can be found in §60, Chapter 10 (Home Health), of the Medicare Claims Processing Manual.

Termination of the benefit during the episode is discussed in III.D. 1. B., below.

2. **General Billing Instructions for No Payment Claims with Condition Code 21 (Other than HH PPS).** No payment claims are sometimes referred to **as "billing for denials/denial notices"**. In summary, instructions applicable to all bill types other than HH PPS claims are:

- **Condition code 21 must be used**;
- **All charges must be submitted as noncovered**;
- **No use of modifiers signifying provider liability** (see III. G. below);
- **Frequency code 0** (zero) **must be used** in the third position of TOB of the claim, though the frequency codes 7 and 8 may be used when appropriate for provider-submitted claim adjustments/cancellations;
- **Total charges must equal the sum of noncovered charges**;
- **Basic required claim elements must be completed**; and
- **Statement dates should conform to simultaneous claims for payment**, if any.

If claims do not conform to these requirements, they will be returned to providers. *However, in the case of overlapping statement dates, the incoming overlapping claim using condition code 21 will be processed to completion as a rejection, with a unique reason code explaining the reason for the rejection. Providers can then correct and re-submit the claim assuming the overlap was a billing error.* Noncovered charges billed on these claims *when not rejected* will be denied as beneficiary liable. *Such denials can only be overturned on appeal.*

C. Summary of All Types of No Payment Claims [Table 3]

With this instruction, all entirely noncovered claims submitted to Medicare 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. All outpatient, inpatient Part B and hospice TOBs must use either condition code 20 or 21 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
Frequency Code 0 on	**Condition 1** – Noncovered claim for	All charges submitted as noncovered; use **only for**	Medicare will deny all services on such bills;

Code 0 on Inpatient Hospital, Swing Bed, RNHCI or SNF Claims	Noncovered claim for which provider is liable, **NO notice requirement, OR** **Condition 1** - Updating utilization of an inpatient benefit with a claim **AND** **Condition 2 - Notice of non-coverage** *or equivalent form*	noncovered; use **only for inpatient Part A services (i.e., TOB 11x, 18x, 21x, 41x)**	provider or beneficiary liable, but the beneficiary must be given a notice of non-coverage before being held liable*

Condition Code 21 with Frequency Codes 7, 8, 0 (for entire noncovered claim)	**Condition 1** – Voluntary notice of statutory exclusion 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),** OR **Condition 2 – HHABN or SNFABN, Option A** on form, custodial care only	All charges for all line items on claims using this code must be submitted as noncovered, **all providers can submit****	Medicare will deny all services on these claims in all cases and will hold beneficiary liable for payment on these denials
Condition Code 20 on finalized Outpatient 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

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

**** Noncovered claims can only be submitted for OPPS 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: **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.

D. Traditional Demand Bills (Condition Code 20)

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 and home health, TOBs 21x, 32x and 33x), and required the provider submit additional documentation for development to enable determination of the medical justification for the service(s) in question.

This process is being revised with this instruction. First, if an ABN is given, special billing requirements apply (see III.E. below), 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 III. D. 1., "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.

See specific instructions and exceptions for inpatient SNF and home health in III. D. 1. a.-*d*., immediately below; and
General demand billing instructions for all other provider types are in III. D. 2.

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 the *Medicare Claims Processing 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 I. and III. A. and B. above, 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.

1. 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).

a. HH PPS. There are special instructions for **HH PPS demand bills**. Such special instructions must be followed if: **(1)** An HHABN is required, or **(2)** 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 III. B. 1., above.

b. Refinements for HH PPS. HHABN policy has continued to change, but current documentation of this policy can be found in:

- The ABN Web site (cited in I. A. above); and

- Chapter 30 (Financial Liability Protections), §60, of the Medicare Claims Processing Manual.

1. Independent Assessment. Billing questions relative to the HHABN and home health assessments have persisted. With regard to payment liability for the assessment itself, the assessment is a noncovered service that is not a Medicare benefit and is never separately payable by Medicare. In all cases of statutory exclusions, a choice remains: the provider may or may not decide to hold the beneficiary liable, and Medicare cannot specify which is appropriate because the service at issue is outside Medicare's scope.

If a decision is made to hold a beneficiary liable for just the assessment, CMS believes providers must be in compliance with the home health COPs, as follows:

> **484.10.e (1)** The patient has the right to be advised, before care is initiated, of the extent to which payment for the HHA services may be expected from Medicare or other sources, and the extent to which payment may be required from the patient. Before care is initiated, the HHA must inform the patient, **orally and in writing**, of: (i) The extent to which payment may be expected from Medicare, Medicaid or any other Federally funded or aided program known to the HHA; (ii) The charges for services that will not be covered by Medicare; and (iii) The charges that the individual has to pay.
>
> Therefore, while no notice may be required if the provider chooses to be liable, the conditions state **a notice is required if the beneficiary is to be held liable**, and must be delivered **prior** to the service in question. Since the HHABN is **not** appropriate in these cases, the provider is free to develop their own written notice, but Medicare does have a voluntary form, the NEMB (see section I.A. above), that could be used for this purpose.

2. Termination of the Benefit During the Episode Period. The HHABN is likely to be warranted in cases when only non-skilled, not medically necessary or noncovered services remain to be delivered under the plan of care, or when the beneficiary is no longer homebound, during the 60 days of the original episode period. These situations can be triggering events under existing HHABN policy (i.e., termination of the benefit), since the close of the episode, or the end of the benefit, occurs at this point, and a Medicare "paper" discharge can be done (i.e., the final claim for the episode prepared and submitted). At this point two billing options exist:

a. **If there is no doubt the benefit has been completed, meaning the ordering physician, beneficiary and provider agree Medicare coverage has ended, the HHA has the option of billing the balance of the 60 day period remaining after the benefit has ended on a no payment claim as described in section III. B. 1.** above. As with other statutory exclusions or services not part of a recognized Medicare benefit, notification of the beneficiary as to his/her liability prior to delivery of the service if the provider intends to charge may still be required by the HH COPs. A form such as the NEMB can be used in these cases.

b. **If there is doubt/dispute as to the benefit is continuing, the whole 60-day episode period must be billed on a single HH PPS demand bill,** and HHABNs must be given when triggering event(s) occur.

3. Billing in Excess of the Benefit. In some states, the Medicaid program will cover more hours of care in a week than the Medicare benefit. Therefore, a HHA may be billing hours/visits in excess of the benefit during a Medicare home health episode for a dually eligible beneficiary. Since the care delivered in excess of the benefit is not part of the benefit, and does not affect the amount of Medicare's prospectively set payment, there is no dispute as to liability, and a HHABN is not required unless a triggering event occurs; **that is, care in excess of the benefit is not a triggering event in and of itself requiring an ABN**. Billing services in excess of the benefit is discussed in Chapter 10 (Home Health), §50 C., of the MCPM.

4. One-Visit Episodes. Since intermittent care is a requirement of the Medicare home health benefit, questions often arise as to the billing of one-visit episodes. **Medicare claims systems will process such billings, but these billings should only be done WHEN some factor potentially justifies the medical necessity of the service relative to the benefit**.

Many of these cases do not even need to be demand billed, because coverage is not in doubt, since physician orders called for delivery of the benefit. When the beneficiaries dies after only one visit is a clear-cut example. When physician orders called for additional services, but the beneficiary died before more services could be delivered, the delivery of only one visit is covered. The death is clearly indicated on the claim with use of patient status code 20. Other cases in which

orders clearly called for additional services, but circumstances prevented delivery of more than one service by the HHA, are also appropriately billed to Medicare in the same fashion.

There may be rare cases where, even though orders do not clearly indicate the need for additional services, the HHA feels delivery of the service is medically justified by Medicare's standard, and should be covered. **In such situations, when doubt exists, a HHA should still give the beneficiary a HHABN if a triggering event has occurred, explaining Medicare may not cover the service, and then demand bill the service in question**.

No billing is required when there is no dispute that the one service called for on the order does not meet the requirements for the Medicare home health benefit, or is not medically necessary. However, there are options for billing these noncovered services as discussed in III. A-B; note the COPs may require notification in this situation if the beneficiary is to be held liable, as discussed in III. D. 1.b. 1. immediately above.

c. 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 the *Medicare Claims Processing Manual*; and

- **Note ABN form 131-G, or 131-L for lab services only, are used with Part B SNF claims in accordance with existing *outpatient or Part B* ABN instructions**, ***though the term ABN may also now be associated with notices of non-coverage (see Chapter 30, §70).***

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 Chapter 1 (General Claims Processing), §30.1.1, of the *Medicare Claims Processing Manual*, 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.

d. Use of Noncovered Bills in Cases of Custodial Care under SNF PPS, or Termination of the Benefit during the Spell.

The use of no payment claims in association with an ABN for SNF involving custodial care or termination of a benefit during a spell is a clarification of CMS

*policy. In cases where the SNF plan of care prescribes only custodial care, or if the inpatient benefit has terminated during a spell, **AND** the physician, beneficiary and provider are all in agreement the benefit has terminated/does not apply, SNFs can use the following procedures **instead of demand billing**:*

- *The SNFABN for notification of the beneficiary, selecting Option 1 on that form; and*

- *A condition code 21 no payment claim to bill all subsequent services when no covered charges have accrued for the monthly billing cycle.*

NOTE: *Providers can never pre-select ABN options for beneficiaries, in accordance with existing ABN policy. In each case, the beneficiary must be consulted as to the option the above, is only an illustration, and not an authorization for pre-empting a beneficiary's right to choose a specific option.*

General instructions for the preparation of no payment claims can be found in §60.1.3, Chapter 1 of the Medicare Claims Processing Manual.

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

New with this instruction, in addition to current home health and SNF requirements (in III. D. 1. above), all other provider types, including HH service NOT paid under HH PPS (i.e., TOB 34x), AND inpatient services (TOBS 11x, 21x, 18x and 41x) are required to submit demand bills using condition code 20 when requested by beneficiaries. Traditionally, **hospices** are the only other category of providers that have received specific guidance from FIs/RHHIs on using this type of demand bill. FIs/RHHIs perform review of such bills, for reasons such as medical necessity, coverage and payment liability issues, although inpatient hospital bills (TOB 11x) are sent to the Quality Improvement Organizations (QIOs), formerly the Peer Review Organizations (PROs)) for medical necessity determinations exclusively.

However, for other outpatient billing, this is ONLY in cases when an ABN is not given/not appropriate when coverage is in doubt. Also, services that the provider is sure are noncovered, such as statutory exclusions outside a recognized Medicare benefit, should never be demand billed through this process UNLESS specifically requested by a beneficiary (i.e., the beneficiary wants a determination, not just billing for denial). Interim bills, final bills or adjustment requests may be used to demand bill.

Other covered services may appear on these claims, but not other noncovered charges, as all noncovered charges on demand bills will be considered in dispute

and in need of review. Allowing covered and noncovered services to come in on demand bills will allow all services provided in the statement covers period to be billed, though payment of the covered services will be delayed by the review and development of the noncovered charges. **For this reason, providers should break out demand billed services to separate claims for discrete time period, with all noncovered charges whenever possible**. Such claims must contain at least one noncovered charge at issue, or the claims with condition code 20 will be returned to the provider.

Funds may be collected from beneficiaries in advance of the determination of liability resulting from medical review of a demand bill (note exception for SNFs in III. D. 1. c., above). **If the result of such review is that the beneficiary is not liable, as when Medicare pays covered charges, any funds collected in advance must be returned**.

Additionally, *providers* may not collect funds from beneficiaries or subsequent insurers for services for which they know they will be found liable, as they would once educated as to the need to correct routine use of the ABN. That is, demand billing cannot be used as a red herring to hold or retain either beneficiary or subsequent insurer funds for any period of time when the *provider* has reason to know they are fully liable for the services in question.

In summary, other general requirements for demand bills, other than SNF and HH PPS demand bill exceptions, are:

- **Condition code 20 must be used**;

- **All charges associated with condition code 20 must be submitted as noncovered**, all noncovered services on the demand bill must be in dispute, and at least one noncovered line must appear on the claim, but unrelated covered charges must be allowed on the same claim (unrelated noncovered charges not in dispute, if any, would be billed on a no payment claims using condition code 21 for outpatient bill types—see III. B. above);

- **Frequency code zero should be used if** all services on the claim are noncovered;

- **Conditions codes 20 and 32 (i.e., ABN) are NEVER submitted on the same claim;** and

- **Basic required claim elements must be completed**.

Claims not meeting these requirements will be returned to providers. Unlike entirely noncovered outpatient claims using condition code 21, no claims may be submitted simultaneously with demand bills, EXCEPT no payment claims for

outpatient bill types using condition code 21, with statement period equal to or fitting within the demand bill statement period. This is true even if only charges associated with the condition code 20 are submitted on the claim, and therefore it is an entirely noncovered claim. No payment bills using condition code 21 are only used for services that are **not** in dispute, as opposed to noncovered charges on demand bills. This restriction is required because some services on demand bills may be found covered upon review, unlike no payment claims where there is no expectation of coverage/payment. Avoiding overlaps with other than entirely no payment claims will also prevent claims from being rejected as duplicates. . *If received, the incoming overlapping claim using condition code 20 will be processed to completion as a rejection, with a unique reason code explaining the reason for the rejection. Providers can then correct and re-submit the claim, assuming the overlap in periods was a billing error.*

Also new with this instruction, providers should be aware CMS may require development of any noncovered charge on traditional demand bills. In addition to this review, such services will then be paid, RTP'ed, rejected or denied in accordance with other instructions/edits applied in processing to completion.

E. Billing With an ABN (Use of Occurrence Code 32) Comparable to Traditional Demand Bills

Now, using an ABN is frequently required, much more often than traditional demand billing, usually when medical necessity is in doubt, or *when* other issues captured in §1862(a)(1) and §1879 of the Act apply, or when previous covered treatment is to be reduced or terminated within a Medicare benefit. Previous ABN instructions brought about a large change in billing practices, because before *these instructions,* covered charges were never billed when medical necessity was in doubt.

Claims billed in association with an ABN, *other than **HHPPS** and **SNF PPS** exceptions*, never use condition code 20 or 21*, and will be returned to providers if received,* but instead:

- **Must use a claim-level occurrence code 32** to signify all services on the claim are associated with one particular ABN given on a specific date (**unless** the use of modifiers, discussed below, makes clear not every line on the claim is linked to the ABN);

- **Must provide the date the ABN was signed** by the beneficiary in association with the occurrence code;

- **Occurrence code 32 and accompanying date must be used multiple times if** more than one ABN is tied to a single claim for services that must be bundled/billed on the same claim (i.e., one date for one ABN lab

services tied to a R-131-L, another for services tied to a R-131-G, even if the date is the same for both ABNs);

- **Must submit all ABN-related services as covered charges** ***(note –GA modifier exception, below)*****; and**

- **Must complete all basic required claim elements** as for other comparable claims for covered services.

Again, if an ABN is given, these billing procedures must be used, rather than traditional demand billing. **New with this instruction, providers should be aware CMS may require suspension of any claims using occurrence code 32 for medical review of covered charges associated with an ABN**. Citations for instructions on the ABN, which include information on when an ABN is appropriate, are given above. If claims using occurrence code 32 remain covered, they will be paid, RTP'ed, rejected or denied in accordance with other instructions/edits applied in processing to completion. Denials made through automated medical review of service submitted as covered are still permitted after medical review, and the FI will determine if additional documentation requests or manual development of these services are warranted. For all denials of services associated with the ABN, the beneficiary will be liable.

The –GA modifier is used when provider must bill services related and not related to an ABN on the same claim. See § G. below for more information this modifier, but note that in the case when it is used both covered and noncovered service may appear on the ABN-related claim.

F. Summary of Methods for Demand Billing [Table 4]

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 4:

Situation and Notice Requirement	Description/Charges	Applicable Providers
No ABN or HHABN required, beneficiary not in a HH PPS episode, *beneficiary in SNF PPS episode or otherwise* requests a demand bill be submitted (i.e., for a service excluded by statute)	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 (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 (131-L** --lab services only; and **131-G** -- all other services)* **NOTE**: 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.

G. Line-Item Modifiers Related to Reporting of Noncovered Charges When Covered and Noncovered Services Are on the Same Claim [Tables 5 and 6]

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 5:

Source of the Modifier List	Modifiers	Claims Processing Instructions	Definition Source
HCPCS Modifiers <u>Not Covered</u> or <u>Not Payable</u> by Medicare by Administrative Instruction Attached to Definition	-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 2003 publication of HCPCS codes by CMS
CPT/HCPCS Modifiers Permitted on OPPS Claims (Transmittal/ PM: A-02-129)	**CPT**: -25, -27, -50, -52*, -58, -59, -73*, -74*, -76, -77, -78, -79, -91 **HCPCS**: -CA, -E1 through -E4, -FA, -F1 through -F9, -GA, -GG, -GH, -GY, -GZ, -LC, -LD, -LT, -QM, -QN, -RC, -RT, -TA, -T1 through -T9	**FI standard systems accept these modifiers for processing on OPPS claims** (**TOBs: 12, 13, 14**) in accordance with HCPCS/CPT definitions, and in accordance with chart below.	**CPT** numerical modifiers defined in 2003 publication of "CPT Manual" by the American Medical Association; **HCPCS** codes as defined by 2003 publication of HCPCS codes by CMS

Modifiers Used in Billing Ambulance Noncovered Charges (Transmittal A-02-113, new instructions	-GY, -QL, -QM or -QN, -TQ, alpha destination modifiers	Applicable TOBs for ambulance billing: **12x, 13x, 22x, 23x, 83x, 85x**	**See ambulance instructions (III. I.) and chart immediately below**

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 relate to situations where there is no notice requirement, because these charges occur either as treatment begins or after it has started, and Medicare simply reduces the payment to the provider.

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.

By April 2004, when this instruction will be implemented, the Health Insurance Portability and Accountability Act (HIPAA) will require 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). For this reason, CMS does not believe failing to require HCPCS on noncovered line items after this point will benefit institutional providers, and expects most vendors of billing software will program their products to require HCPCS procedure codes if modifiers are used. **Therefore, HCPCS 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

With the implementation of this instruction, 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 of *–KB* cannot be used with this code since *they* require noncovered charges. Modifiers most likely to be used with noncovered charges or liability notices are listed below.

TABLE 6:

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

Mod	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
-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
-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 required, 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**	Use only for ambulance services (TOBs: **12x, 13x, 22x, 23x, 83x, 85x**)	*Mileage* **lines submitted as noncovered** and will be denied

			liable		*denied; base rate line submitted covered*
-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 2 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, RHHIs 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 theses 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 will suspend for review, and if these services cannot be reviewed, they must be released back into processing as covered charges.

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

H. Clarifying 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

Since January 1, 1999, 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: §10-40.5, Chapter 5 (Outpatient Rehabilitation) of the *Medicare Claims Processing Manual*.

Though these instructions are still current and should be followed, they did not previously discuss billing for noncovered charges. This update *to those* instruction*s* allow*s* 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 (transmittal AB-03-057).

Though these instructions are still current and should be followed, they did not previously discuss billing for noncovered charges. This PM updates this instruction in order to allow the submission of noncovered charges. **Outpatient therapies, billed as noncovered charges, are not counted toward the therapy cap 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 (Transmittal AB-03-057).

Critical Access Hospitals (CAHs) -- Although CAHs are not addressed in §10 thru 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 ~~can~~ 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).

- Never split a single increment into a covered and noncovered portion.

I. New Instructions for Noncovered Charges *for Mileage* on Ambulance Claims [Table 7]

Transmittal A-02-113 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 instruction 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, and existing base *ambulance* requirements, such as reporting HCPCS, origin/destination and zip code, still stand, **instructions for reporting ambulance noncovered mileage charges otherwise change with this new guidance**.

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

With the implementation of this instruction, 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. As per previous instructions (CR 1961, Transmittal AB-02-031), 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 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 7:

Mileage Scenario	***HCPCS***	***Modifiers****	***Liab-ility***	***Billing***	***Remit. Require-ments***	***MSN Messag***
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 do not pay for thi item or service"; OR, "Medicare no paga por este artículo o servicio"*
Beneficiary dies after ambulance is called	*Most appropriate ambulance HCPCS mileage code (i.e., ground, air)*	***–QL*** *unless condition code –21 claim*	*Provider*	*Bill mileage line item with* ***–QL*** *as noncovered, line item will be denied*	*Group Code* ***CO*** *for contrac-ual obligation, reason code* ***96*** *for noncovered charges*	***16.58*** *"The provider billed this charge as noncovered. You do not ha to pay this amount."; OR "El proveedor facuró este cargo como n cubierto. Uste*

						no tiene que pagar ests cantidad."
Subsidy or governmen t owned ***Ambulance, Medicare NEVER billed******	***A0888*** *on line item for the noncove red mileage*	***-QM*** *or* ***–QN****, origin/destin- ation 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 bille this charge as noncovered. You do not ha to pay this amount."; OR "El proveedo facuró este cargo como n cubierto. Uste no tiene que pagar ests cantidad."*

** Current ambulance billing requirements state that either the –QM or –QN modifier must be used on all 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." Origin/destination modifiers, also required by current instruction, combine two alpha characters: one for origin, one for destination.*
*** This is the one scenario where the base rate is not paid in addition to mileage, and there ae 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 this particular 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 charged another entity/primary payer, should be submitted as noncovered, 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.*

J. Clarification of Liability for Preventive Screening Benefits Subject to Frequency Limits [Table 8].

Some Medicare preventive benefits are subject to frequency limits, and are also specifically cited at §1862 (a)(1) (F) ff.of the Act as subject to "medical necessity". There has been some confusion as to the basis of denial and how such services are adjudicated. When medical necessity is the basis for denial (i.e., §1862 (a)(1) (F) ff. of the Act), a ABN is necessary in order to shift the liability to the beneficiary, and special ABN-related billing must be used (see III. E. above). Services above frequency limits, however, had been erroneously considered noncovered services by some, and billed as such, not requiring ABNs. In these cases default liability in Medicare systems is the provider, unless specific billing methods and modifiers were used to signal beneficiary liability (see sections III A. and B. above).

Medicare FIs systems have been programmed with frequency as the primary reason for denial, and Medicare carrier systems have used medical necessity. **Effective with this instruction, FI systems must change so that medical necessity is the primary reason for denial. FIs must educate providers as to this change in policy and new required use of the ABN.**

Previously, CMS had confirmed ABNs were not required when frequency limits were exceeded in several different forums, so provider feedback can be expected and special educational efforts required. It also may be contrary to provider practices to submit services over the frequency limit as covered charges, as ABN billing requires; however, it can be pointed out that existing Common Working File (CWF) frequency edits should still result in the denial of these services. Remittance denial reason codes and MSN messages to be used effective with this instruction are listed below for beneficiary and provider liability should either circumstance occur:

TABLE 8:

Preventive Benefit	***HCPCS Code(s)***	***PROVIDER LIABLE (ANSI) Remittance Group and Reason Code***	***PROVIDER LIABLE MSN Message***	***BENE. LIABLE (ANSI) Remittance Group and Reason Code***	***BENE. LIABLE MSN Message***
Screening mammography	G0202, 76092, 76083	CO – 57 [57: Payment denied/reduced because the payer deems the information submitted does not support	15.21 The information provided does not support the need for this many services or items in this period of time but you do not	PR – 57* [57: Payment denied/reduced because the payer deems the information submitted does not	15.22 The information provided does not support the need for this many services or items in this

		this level of service, this many services, this length of service, this dosage, or this day's supply.]	have to pay this amount. [Le informacion proporciona-da no justifica la necesidad do esta cantidad de servicios o articulos an este periodo de tiempo pero usted no tiene que pagar esta cantidad.]	support this level of service, this many services, this length of service, this dosage, or this day's supply.]	period of time so Medicare will not pay for this item or service. [Le informa-cion proporcio-nada no justifica la necesidad do esta cantidad de servicios o articulos an este periodo de tiempo por lo cual Medicare no pagara por este articulo o servicio.]

Preventive Benefit	*HCPCS Code(s)*	*PROVIDER LIABLE (ANSI) Remittance Group and Reason Code*	*PROVIDER LIABLE MSN Message*	*BENE. LIABLE (ANSI) Remittance Group and Reason Code*	*BENE. LIABLE MSN Message*
Screening pap smear	*G0123, G0143, G0144, G0145, G0147, G0148, P3000, Q0091*	*CO - 57*	*Ditto above*	*PR – 57**	*Ditto above*
Screening pelvic exam	*G0101*	*CO - 57*	*Ditto above*	*PR – 57**	*Ditto above*
Screening glaucoma	*G0117, G0118*	*CO - 57*	*Ditto above*	*PR – 57**	*Ditto above*
Prostate cancer screening test	*G0102, G0103*	*CO - 57*	*Ditto above*	*PR – 57**	*Ditto above*
Colorectal cancer screening test	*G0104, G0106, G0107, G0120, G0122*	*CO - 57*	*Ditto above*	*PR – 57**	*Ditto above*

** This ANSI ASC X12 reason code becomes obsolete with implementation of the 835 remittance version 4050. For the purpose of this table, use of 57 in the 835 version 4050 and subsequent versions can be crosswalked to code 151: "Payment adjusted because the payer deems the information submitted does not support this many services".*

IV - General Operational Information on Noncovered Charges

A. Processing of Noncovered Charges in Medicare Claims Processing Systems [Table 9].

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 OPPS OCE, not just OPPS claims. The OPPS OCE has two different edits that are applied to noncovered charges on claims with some covered charges (Edits 9 and 5). 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, the Arkansas Part A and Fiscal Intermediary (APASS and FISS) standard systems, form 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., OPPS**). 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 or standard system are involved in processing claims using these days. The CWF also has it 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 to that 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 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 HUHH) 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, 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, including condition code 21 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 Chapter 1 (General Claims Processing), §60.*5* of the *Medicare Claims Processing Manual*. 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. However, Medicare systems limitations have been encountered by the RHHIs when they have* **employ***ed* **the R code consistently for all outpatient claims, including home health. 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 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 9:

Liability	Remittance Requirement	MSN Message
Beneficiary	Group code **PR** for patient responsibility, reason code **96** for noncovered charges	**16.10** "Medicare does not pay for this item or service."; OR, "Medicare no paga por este artículo o servicio."
Provider	Group Code **CO** for contractual obligation, reason code **96** for noncovered charges	**16.58** "The provider billed this charge as noncovered. You do not have to pay this amount."; OR, "El proveedor facuró este cargo como no cubierto. Usted no tiene que pagar ests cantidad."

ATTACHMENT C **Changes to CR 2634 Business Requirements and Ancillary Documentation**

NOTE: All these changes were made as part of programming CR 2634, no systems changes are being made with CR 3115.

II. BUSINESS REQUIREMENTS

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

Requirement #	Requirements	Responsibility
	2634.1 Series of Requirements – General Non-Systems	
2634.1	FIs/RHHIs should not advise providers to independently adjust or cancel ~~*finalized*~~ *denied* claims, including line items submitted as non-covered and denied, since providers should only be requesting such adjustments be done by the FI/RHHI, especially when such action could result in altering a medical review decision or affecting final payment, with exceptions as noted in the Adjustments section of Chapter One on General Claims in the Medicare Claims Processing Manual (§130 of Chapter 1).	FIs
	2634.2 Series of Requirements – Inpatient Bills only	
2634.2	For claims with type of bill (TOB) 11x, 18x, 21x or 41x, assure claims submitted with frequency code zero have all non-covered charges, with total covered charges equaling zero, **or** total charges equal to total non-covered charges.	FI standard systems**
2634.2.1	If this condition is not met, return the claim to the provider.	FI standard systems**
	2634.3 Series of Requirements - Inpatient and/or Outpatient Bills	
2634.3	Allow all TOBs to use condition code 20 **or** 21 on a given claim with non-covered charges.	FI standard systems**
2634.3.1	Return claims using condition code 21 to providers if **any** covered charges appear on the claim **and/or** if a frequency code other than 7, 8 or 0 (zero) is submitted in the TOB.	FI standard systems
2634.3.2	Return all claims using condition code 21 to providers if modifiers signaling provider liability are used on these claims (i.e., -EY, -GZ, -QL, -TQ*; Attachment B, Table 6*)	FI standard systems
2634.3.3	Allow condition code 20 to be billed on all TOBs, except 32x and 33x, **but** allow on 32x and 33x only when the frequency code is 9 (on TOBs 329 and 339).	FI standard systems
2634.3.3.1	Allow *all* claims with condition code 20 to be entirely non-covered, **or** to have as few as one non-covered charge line.	FI standard systems

2634.3.3.2	Return all claims received using condition code 20 to providers if containing all covered charges (i.e., at least one non-covered charge must appear on the claim), **and/or** if not using the correct frequency code as described in 2634.3.2.	FI standard systems
2634.3.3.3	*Take action on* ~~*Return*~~ claims using condition code 20 ~~*to providers*~~ *, without suspending the claims for medical review,* if the statement covers dates of such claims overlap with the statement covers dates of another of the same provider's claims *in history, as follows in the sub-requirements:*~~*with a covered charge for the same beneficiary.*~~ [**NOTE:** Since these claims may be found covered upon review or appealed, and no more than one statement period should be affected by the simultaneous submission of two claims.]	FI standard systems**
2634.3.3.3.1	*Process the incoming condition code 20 claim to completion as a rejection, whether the history claim is for- or not-for payment, with a unique reason code explaining the reason for the rejection. [Providers can then correct the period and re-submit, or correct the history claim if in the timely filing period.]*	*FI standard systems*
2634.3.3.4	Suspend all claims with condition code 20 for medical review of non-covered charges *by creating a medical policy parameter.*	FI*s* ~~*standard systems*~~
2634.3.3.4.1	Other than HH (TOBs 32x and 33x) and SNF inpatient (TOB 21x) bills, for which CMS has mandated 100 percent review, medically review non-covered charges on all condition code 20 demand bills *to the extent budgetary resources allow*, sending TOBs 11x to Quality Improvement Organizations - QIOs (formerly Peer Review Organizations - PROs) for medical necessity determinations (other determinations, such as coverage and payment liability are done by the FI), determining liability for such charges in the course of review between Medicare (charges found to be covered) and the beneficiary (charges denied).	FIs
	2634.4 Series of Requirements – Outpatient* No Payment Bills	
2634.4	For claims with outpatient TOBs*, assure claims submitted with all non-covered charges-- with total covered charges equaling zero, or total charges equaling total non-covered charges--have condition code 20 **or** 21 present on the claim.	FI standard systems
2634.4.1	If this condition is not met, return the claim to the provider.	FI standard systems
2634.4.2	For claims with outpatient TOBs*, submitted with	FI standard

	condition code 21, allow these claims to be submitted by the same provider for the same beneficiary ~~*simultaneous to*~~*after* submission of claims with covered charges or condition code 20 *for the same time period*, however, assure that statement date period of the non-covered charge claim is equal to or fits within the statement date period of a claim *in history, as follows in the sub-requirement:* ~~with covered charges or condition code 20, if such claims are present~~. [**NOTE:** Since non-covered claims may be appealed, no more than one statement period should be affected by the simultaneous submission of two claims.]	systems**
2634.4.2.1	*Whether the claim in history is a for- or not-for-payment claim, process the incoming condition code 21 claim to completion as a rejection, with a unique reason code explaining the reason for the rejection. [Providers can then correct the period and re-submit, or correct the history claim if in the timely filing period.]*	*FI standard systems*
~~*2634.4.2.1*~~	~~*Return other claims with covered charges or condition code 20 to providers if the claims' statement covers dates overlap those of a previously received non-covered charge claim, such that the statement covers date of the non-covered charge claim does not equal or fit within the statement covers period of a covered charge or condition code 20 claim.*~~	~~*FI standard systems*~~
2634.4.3	Deny all non-covered charges submitted on condition code 21 claims, and hold the beneficiary liable.	FI standard systems**
	2634.5 Series of Requirements – Outpatient* ABN Billing	
2634.5	For all outpatient* TOBs, require all claims received with occurrence code 32 to contain only covered charges **unless** modifier –GA appears on any line item of the claim [**NOTE:** The presence of –GA on line items means line items without the –GA on the same claim do not tie to an ABN; line items not tied to the ABN may be submitted as covered or non-covered. This instruction is an intentional revision to CR 2590 requiring all charges be covered when occurrence code 32 is used.]	FI standard systems
2634.5.1	Return these claims to providers if any non-covered charges appear and the –GA is not used on any line item.	FI standard systems
2634.5.2	Return to providers any claim using occurrence code 32 if condition codes 20 or 21 also appear on that claim.	FI standard systems
2634.5.3	Allow multiple occurrences of occurrence code 32 on these claims.	FI standard systems
2634.5.4	Suspend claims for development that contain occurrence code 32 *by creating a medical policy parameter.*	FI*s* ~~*standard systems*~~
2634.5.4.1	Medically review claims with occurrence code 32 *to the*	FIs

	extent budgetary resources allow, focusing on covered charges associated with the ABN, **and** if review cannot be accomplished, allow claims to complete processing.	
2634.5.4.2	Hold beneficiaries liable for all denied services on claims using occurrence code 32 EXCEPT if the –GA modifier is present on **any** line of the claim; when this modifier is present, hold the beneficiary liable if the line is submitted with –GA, hold providers liable if neither the –GA nor any other modifier signifying beneficiary liability is present (i.e.,-GL, -GY, -TS).	FI standard systems
	Also see requirements 2634.6.1, 2634.4 – 2534.4.4 and 2634.6.14.1.1 in modifier section.	
	2634.6 Series of Requirements – Modifiers	
2634.6	Deny any line item submitted as non-covered with a line-item HCPCS modifier that by definition is either non-covered **or** non-payable by Medicare (see Attachment B, III.G., Table 5, first row below titles).	FI standard systems
2634.6.1	Hold the provider liable for these denials **unless** CMS instructions for discrete modifiers specify to hold the beneficiary liable (see attachment, Section III. H., second table, specifically modifiers -GA, -GL, -GY, -TS), or for all lines on a claims using occurrence code 32 if no –GA modifier appears on that claim.	FI standard systems
2634.6.2	Return to providers any claims submitted with line-item modifier –GK.	FI standard systems
2634.6.3	If the modifier –EY is received on non-covered line items with TOBs ~~*13x, 14x,*~~ 21x, 22x, 32x, 33x, 34x, *74x, 75x, 76x,* 81x or 82x, deny the line item as provider liable.	FI standard systems
2634.6.3.1	For these TOBs, return claims to providers with –EY **and** any modifier requiring covered charges (-GA, -KB) on the same line.	FI standard systems
2634.6.3.2	If the modifier –EY is received on line items with covered charges on claims with TOBs ~~13x, 14x,~~ 21x, 22x, 32x, 33x, 34x, 74x, 75x, 76x, 81x or 82x with covered charges, return the claim to the provider.	FI standard systems
2634.6.4	On all outpatient TOBs*, if the modifier –GA is used on a claim with occurrence code 32, require the modifier –GA to be submitted on at least one line item with covered charges.	FI standard systems
2634.6.4.1	Return claims to providers if the line item modifier –GA is used on a line with non-covered charges.	FI standard systems
2634.6.4.2	Return claims to providers if occurrence code 32 is not present when the –GA modifier is used.	FI standard systems
2634.6.4.3	If line(s) using the modifier –GA are denied *in medical review*, hold the beneficiary liable *by using a medical policy parameter*.	FI*s* ~~*standard systems*~~

2634.6.4.4	Return claims to providers if they contain a line items using both HCPCS code A9270 and the –GA *or –KB* modifier. [A9270 required non-covered charges, -GA covered charges.]	FI standard systems
2634.6.5	Accept modifier –GL on non-covered line items with TOBs 32x, 33x, and 34x only.	FI standard systems
2634.6.5.1	Return claims to providers if the –GL modifier is submitted on line items with covered charges **and/or** TOBs other than as listed in 2634.5.	FI standard systems
2634.6.5.2	When non-covered line item(s) submitted with the modifier –GL are denied, hold the beneficiary liable.	FI standard systems
2634.6.6	Return claims to providers if the –GY modifier is submitted on a line with covered charges.	FI standard systems
2634.6.6.1	When non-covered line item(s) submitted with the modifier –GY are denied, hold the beneficiary liable.	FI standard systems
2634.6.7	Return claims to providers if the –GZ modifier is used on a line item with covered charges.	FI standard systems
2634.6.7.1	When non-covered line item(s) submitted with the modifier –GZ are denied, hold the provider liable.	FI standard systems
2634.6.8	If the –KB modifier is used, require the –KB modifier be submitted on a line with covered charges on TOBs 32x, 33x, 34x.	FI standard systems
2634.6.8.1	Return claims to providers if the –KB modifier is submitted on line items with non-covered charges **and/or** on claims with TOBs other than 32x, 33x or 34x.	FI standard systems
2634.6.8.2	Suspend claims for development if –KB modifier is submitted on a ~~*non-*~~covered line *by using a medical policy parameter*.	*FI*s ~~standard systems~~
2634.6.8.2.1	Develop claims with the -KB modifier and determine liability; do not hold the beneficiary liable **unless** development of the claim shows a reason to hold the beneficiary liable.	RHHIs
2634.6.8.2.2	Educate providers that the –KB modifier should not be used on a line item unless there is a reason that more than two or four modifiers have to be used when a beneficiary requests a DME upgrade. [**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 FISS and APASS systems to take in four modifiers on a line with direct EDI submission, educate that it is appropriate to use this modifier when three modifiers are needed if there is a two-modifier limit.]	RHHIs
2634.6.9	Require modifier~~s~~ –TQ ~~**or –QL**~~ to be submitted on a line with non-covered charges.	FI standard systems
2634.6.9.1	Return claims to providers if this condition is not met.	FI standard systems

2634.6.10	Return claims to providers if the –TQ **or** –QL modifier is submitted on TOBs other than 12x, 13x, 22x, 23x, 83x or 85x.	FI standard systems
2634.6.10.1	Return claims to providers if this condition is not met.	FI standard systems
2634.6.11	When non-covered line item(s) submitted with the modifiers –QL or –TQ are denied, hold the provider liable.	FI standard systems
2634.6.12	Return claims to providers if the –TS modifier is submitted on a line with covered charges.	FI standard systems
2634.6.12.1	When non-covered line item(s) submitted with the modifier –TS are denied, hold the beneficiary liable.	FI standard systems
2634.6.13	Assure that HCPCS code A9270 will be accepted when submitted with non-covered charges on all outpatient TOBs*.	FI standard systems**, OCE (both versions)
2634.6.14.1	Deny all line items using A9270 and hold providers liable **unless** modifiers -GL, -GY~~, –KB~~ or –TS appear.	FI standard systems
2634.6.15 ~~2634.6.14.1.1~~	When ~~these~~ modifiers are used *indicating beneficiary liability (i.e., -GA, -GL, -GY, -KB, -TS), whether on lines submitted as covered or non-covered*, ~~*or if modifier –GA is used,*~~ or for all line items on claims using occurrence code 32 when no –GA modifier is present on the claim, hold the beneficiary liable, **and** modify OCE W7009 and W0235 as needed.	FI standard systems, OCE
2634.6.16 ~~*2634.6.15*~~	Return claims to providers if line-item modifiers are billed on non-covered line items without the use of a HCPCS code.***	FI standard systems
	2634.7 Series of Requirements – Outpatient Therapies	
2634.7	*Process to completion and reject* ~~*Return*~~ claims ~~*to providers*~~ when the same outpatient therapy codes (TOBs and HCPCS in §10 thru §40.5 in Chapter 5 (outpatient therapies) of the Medicare Claims Processing Manual (formerly §3653, Part 3, of the Medicare Intermediary Manual)*) are* ~~*to be*~~ billed on non-covered claims for the same patient by the same provider on the same day ~~*as on both*~~ a covered ~~*and non-covered*~~ claim. *[Providers can then correct and re-submit all services for the same day on the same claim.]*	FI standard systems
	2634.8 Series of Requirements - Ambulance	
2634.8	Assure that HCPCS code A0888 will be accepted when submitted with non-covered charges on TOBs 12x, 13x, 22x, 23x, 83x or 85x.	FI standard systems, OCE (both versions)
2634.8.1	Return to providers claims with non-covered line(s) with covered charges on the line reflecting ~~*obsolete instructions*~~ *CR 1476 (Year 2000 Transmittal AB-00-131).*	FI standard systems
2634.8.2	For denied line items when HCPCS code A0888 and the –GY modifier are used for the circumstance of miles	FI standard systems

	beyond the closest facility *and pick-up outside the U.S.*, use Group Code PR and Reason Code 96 on the remittance, and use Message ~~*1.1*~~ *16.10* on the MSN.	
2634.8.2.1	*Require Group Code CO and MSN message 16.58 for the ~~two~~ other non-covered mileage lines on the claim ~~scenarios~~: beneficiary died after ambulance was called ~~and subsidy or government-owned ambulance~~ --the beneficiary dying scenario will use modifier –QL; and the other scenario, the subsidy scenario when charges are never incurred, will be submitted using HCPCS Code A0888 and modifier –TQ.*	*FI standard systems*
2634.8.2.2	*Return to providers claims using the HCPCS Code A0888 if neither the modifier –GY nor –TQ appear on the line item using the code.*	*FI standard systems*
~~2634.8.3~~	~~Pass non-covered line items with the modifier –TQ to PS&R~~	~~FI standard systems (financial core)~~
~~2634.8.3.1~~	~~Display non-covered ambulance charges that use the modifier –TQ~~	~~PS&R~~
	2634.9 Series of Requirements - Screening Frequency Benefits	
2634.9	Assure medical necessity is the primary reason for denial of screening frequency benefits by using appropriate ANSI remittance reason codes and MSN messages as provided in Attachment B, Table 8	FI*s* ~~*standard systems*~~
	2634.10 -.18 Series of Requirements - General Non-covered Charge Systems Requirements	
2634.10	When the provider is liable **and** no other messages are specified for line items submitted as non-covered charges and denied, use group code CO and reason code 96 on the remittance, and Medicare Summary Notice (MSN) messages 16.58.	FI*s* ~~*standard systems*~~
2634.11	When the beneficiary is liable **and** no other messages are specified for line items submitted as non-covered charges and denied, use group code PR and reason code 96 on the remittance, and Medicare Summary Notice (MSN) message 16.10.	FI*s* ~~*standard systems*~~
2634.12	Bypass duplicate edits on entirely non-covered claims, **or** on non-covered line items, received on all outpatient* TOBs, UNLESS the history claim has been medically reviewed*, or unless condition code 20 is on the claim.*	FI standard systems
2634.13	Bypass Part B duplicate edits on entirely non-covered claims, **or** non-covered line items, received on all outpatient* TOBs.	CWF****
2634.13.1	*Override bypass of Part B duplicate edits if exactly the same data appears on both claims, including the same*	*CWF*

	ICN.	
2634.14	Bypass A-B crossover edits for entirely non-covered claims, **or** non-covered line items, received on all outpatient TOBs.	CWF****
2634.15	Bypass utilization edits for entirely non-covered claims, **or** non-covered line items, received on all outpatient* TOBs.	CWF****
2634.15.1	*Do not bypass utilization edits if applying hospice claims to hospice benefit periods OR if involving beneficiary entitlement on all types of claims. [i.e., claims subject to edits that confirm beneficiaries are not entitled to Medicare to not have to be edited further for non-covered charges.]*	*CWF*
2634.16	Bypass consistency edits on entirely non-covered claims, **or** non-covered line items, received on all outpatient* TOBs, if the consistency edits are specific to particular billing situations, **NOT** if the edits relate to validity of data in required claim elements (ex., HIC number, provider number).	CWF****
~~*2634.17*~~	~~*Use the R no-payment code consistently for all outpatient claims, including home health, for which any of spell information, co-payment or deductible must be updated.*~~	~~*RHHIs*~~
~~*2634.18*~~	~~*Update home health value codes 62-65 when the R code is used with zeros, since these value codes are needed to effectuate information related to the A-B Shift in the home health spell.*~~	~~*FI Standard Systems*~~
~~*2634.19*~~	~~*Update the dates of earliest and latest billing activity Date of Earliest Billing Activity (DOEBA) and Date of Latest Billing Activity (DOLBA) associated with the benefit period (not the episode) when the R no payment code is used on home health claims, and bypass consistency edits based on the R no payment code.*~~	~~*CWF*~~

* For "outpatient"—see Attachment A.

*** Testing done as part of programming the instruction confirmed the FISS systems performed this requirement prior to this instruction.*

**** The FISS standard system requires procedural HCPCS codes to be present on line-items using a modifier, whether covered or non-covered.*

***** Neither NOEs nor CWF unsolicited responses are affected by this instruction.*

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions

2634.2-2634.3.3.4; 2634.4-2634.5.4; 2634.5.4.2-2634.6.8.2; 2634.6.9-2634.8; 2634.8.2-2634.8.2.1; 2634.11-2634.16; ~~*2634.18*~~	Inputs are claims as described in these requirements
2634.8.1, 2634.9, 2634.10	Outputs are the remittance and MSN

B. Design Considerations:

X-Ref Requirement #	Recommendation for Medicare System Requirements
2634.3.3.4	Consider use of distinct reason codes for different TOBs being reviewed
2634.5.4, 2634.6.4.3, 2634.6.8.2	Consider use of medical policy parameters by users instead of shared system coding
2634.13-.16	Cost avoids should not be part of the bypass logic (no-pay codes E, F, G, H, J, K, Q, T, U, V, Y, 00, 12, 13, 14).

60.1 - General Information on Noncovered Charges

(Rev. 133, 04-02-04)

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 under §1862(a)(1) of the Act can relate to services not being reasonable and necessary, §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. 133, 04-02-04)

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). 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/medlearn/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 Sarrassat 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/

(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--including Part B SNF, HHA not under a plan of care, CORF and outpatient hospital-- and hospice services ONLY among FI-billed services. 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
- *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 from (i.e., CMS Form 10055 for SNF)*	*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.*

60.1.2 - Services Excluded by Statute

(Rev. 133, 04-02-04)

Medicare will not pay for services excluded by statute, which often are services not recognized as part of a covered Medicare benefit. Examples of such services are given to beneficiaries in the "Medicare and You" handbook, at the end of the "Part A/Part B Cost and Coverage" subsection under Section 4 on the "Original Medicare Plan". Such services cannot necessarily be recognized in the definition of a specific procedure or diagnosis code. For example, under some conditions, a given code may be covered as part of a given benefit, but under other cases when no benefit is applied, the same code would not be covered. For claims submitted to FIs/RHHIs, these services may be: (1) Not submitted to Medicare at all, (2) Submitted as noncovered line items, or (3) Submitted on entirely noncovered claims.

A. Medicare does not require procedures excluded by statute to be billed on institutional claims submitted to FIs/RHHIs UNLESS: Medicare does not require procedures excluded by statute be billed unless: (1) Established policy requires either all services in a certain period, covered or noncovered, be billed together so that all such services can be bundled for payment consideration (i.e., procedures provided on the same day to beneficiaries under OPPS), or billing is required for reasons other than payment (i.e., utilization chargeable in inpatient settings); or (2) A beneficiary requests Medicare be billed in a manner that the service in question will be reviewed by Medicare (more on demand billing in §60.3 in this chapter).

B. To submit a noncovered line item on a claim with other covered services (Payment Liability Conditions 1 and 3), use the modifier –GY on all line items for statutory exclusions. Submit all charges for those item(s) as noncovered charges, and otherwise complete the claim as is appropriate for the covered charges. More information is given on the –GY modifier (see §60.4.2 in this chapter). This option should only be used when providers are unable to split noncovered services onto a separate claim ((3) below).

C. To submit statutory exclusions on entirely noncovered claims (Payment Liability Condition 1 only), use condition code 21, a claim-level code, signifying <u>all</u> charges that are submitted on that claim are noncovered charges. No –GY modifiers need be attached to any of the procedure codes on such a claim, and all charges must be submitted as noncovered (see §60.1.3 in this chapter).

60.1.3 - Claims With Condition Code 21

(Rev. 133, 04-02-04)

Condition code 21 can be employed to indicate no payment outpatient claims are being submitted for other reasons in addition to §60.1.2. above:

- *At a beneficiary's, or other insurer's, request, to obtain a denial from Medicare on any kind of noncovered charges, to facilitate payment by subsequent insurers (ex., statutory exclusions outside Medicare benefits, such as most self-administered drugs; no modifier is required to establish liability);*

- *With an HHABN in special cases (see Chapter 10, §60, of this manual);*

- *With a SNFABN in special cases (see Chapter 6, §40.7, of this manual).*

A. General Billing Instructions for No Payment Claims With Condition Code 21 (Other than HH PPS).

No payment claims are sometimes referred to as "billing for denials/denial notices". In summary, instructions applicable to all bill types other than HH PPS claims are:

- *Condition code 21 must be used;*

- *All charges must be submitted as noncovered;*

- *No use of modifiers signifying provider liability (see §60.4.2 this chapter);*

- *Frequency code 0 (zero) must be used in the third position of TOB of the claim, though the frequency codes 7 and 8 may be used when appropriate for provider-submitted claim adjustments/cancellations;*
- *Total charges must equal the sum of noncovered charges;*

- *Basic required claim elements must be completed; and*

- *Statement dates should conform to simultaneous claims for payment, if any.*

If claims do not conform to these requirements, they will be returned to providers. However, in the case of overlapping statement dates, the incoming overlapping claim using condition code 21 will be processed to completion as a rejection, with a unique reason code explaining the reason for the rejection. Providers can then correct and re-submit the claim assuming the overlap in periods was a billing error. Noncovered charges billed on these claims when not rejected will be denied, and beneficiaries will be liable. Such denials can only be overturned on appeal.

60.1.4 - Summary of All Types of No Payment Claims

(Rev. 133, 04-02-04)

All entirely noncovered claims submitted to Medicare 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. All outpatient, inpatient Part B and hospice TOBs must use either condition code 20 or 21 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***
Frequency Code 0 on Inpatient Hospital, Swing Bed, RNHCI or SNF Claims	*Condition 1 – Noncovered claim for which provider is liable, NO notice requirement OR Condition 1 - Updating utilization of an inpatient benefit with a claim AND Condition 2 - Notice of non-coverage or equivalent form*	*All charges submitted as noncovered; use only for inpatient Part A services (i.e., TOB 11x, 18x, 21x, 41x)*	*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**
Condition Code 21 with Frequency Codes 7, 8, 0 (for entire noncovered claim)	*Condition 1 – Voluntary notice of statutory exclusion 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)* ***OR*** *Condition 2 – HHABN or SNFABN, Option A on form, custodial care only*	*All charges for all line items on claims using this code must be submitted as noncovered, all providers can submit***	*Medicare will deny all services on these claims in all cases and will hold beneficiary liable for payment on these denials*

*Condition Code 20 on finalized Outpatient 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*

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

** *Noncovered claims can only be submitted for OPPS 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 Noncovered Charges

(Rev. 133, 04-02-04)

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 OPPS OCE, not just OPPS claims. The OPPS OCE has two different edits that are applied to noncovered charges on claims with some covered charges (Edits 9 and 5). 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., OPPS). 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 or standard system are involved in processing claims using these days. The CWF also has it 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 claims 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 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 HUHH) 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, including condition code 21 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***
Beneficiary	*Group code PR for patient responsibility, reason code 96 for noncovered charges*	*16.10 "Medicare does not pay for this item or service."; OR, "Medicare no paga por este artículo o servicio."*
Provider	*Group Code CO for contractual obligation, reason code 96 for noncovered charges*	*16.58 "The provider billed this charge as noncovered. You do not have to pay this amount."; OR, "El proveedor facuró este cargo como no cubierto. Usted no tiene que pagar ests cantidad."*

60.2 - Noncovered Charges on Inpatient Bills

(Rev. 133, 04-02-04)

No Payment Inpatient Hospital and SNF Claims. Where stays begin with a noncovered level of care and end with a covered level, only one claim is required for both the noncovered and covered period, which must be billed in keeping with other billing frequency guidance (i.e., SNFs are required to bill monthly). However, SNFs and inpatient hospitals are required to submit discharge bills in cases of no payment. These bills must correctly reflect provider and beneficiary liability (see Chapter 6, §40.6.4 of this manual)

For SNFs, provider-liable no payment bills should be submitted before discharge in order to assure utilization chargeable periods are clearly posted.

For inpatient hospital PPS claims that cannot be split into covered and noncovered periods, hospital providers can submit occurrence span code 77 for provider-liable noncovered periods, and occurrence span code 76 for beneficiary-liable noncovered periods.

These procedures must be followed for Part A inpatient services (TOBs: 11x (hospital), 18x (swing bed), 21x (SNF), 41x (religious non-medical health care institutions—RNHCI)), but are not required for inpatient Part B. These no payment bills contain:

- *All charges submitted as noncovered;*
- *Frequency code 0 (zero) to be used in the third position of the type of bill (TOB) form locator of the original claim (i.e., not adjustment or cancellation) [NOTE: If providers do not submit no payment claims with this frequency code, the standard systems may already act to change the frequency code to 0 or return the claim to the provider*];
- *Total charges equal the sum of noncovered charges;*
- *Basic required claim elements must be completed;*
- *Note units are not required when reporting noncovered days on SNF and Inpatient Rehabilitation claims using Health Insurance Prospective Payment.*

Note units are not required when reporting noncovered days on SNF and Inpatient Rehabilitation claims using Health Insurance Prospective Payment Systems (HIPPS) codes.

Claims that do not conform to these requirements will be returned to providers. For SNFs, occurrence code 22 should also be used on no payment claims when SNF care is reduced to a noncovered level and benefits had previously been exhausted. This instruction is consistent with §40.7, Chapter 6 (Inpatient SNF) in this manual.

Current instructions for inpatient no payment claims are found in the following locations:

- *§40.7, Chapter 6 (Inpatient SNF), in this manual; and*
- *§40.4, Chapter 3 (Inpatient Hospital), in this manual*.

For discussion of new and existing demand bills, which may be entirely noncovered, or contain some noncovered charges, see §60.3 immediately below.

60.3.1 - Traditional Demand Bills (Condition Code 20)

(Rev. 133, 04-02-04)

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*

- *Note ABN Form 131-G, or 131-L for lab services only, are used with Part B SNF claims in accordance with existing outpatient or Part B ABN instructions, though the term ABN is also now associated with notices of non-coverage (Chapter 30, §70).*

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.

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

(Rev. 133, 04-02-04)

In addition to current home health and SNF requirements, all other provider types, including HH service NOT paid under HH PPS (i.e., TOB 34x), AND inpatient services (TOBS 11x, 21x, 18x and 41x) are required to submit demand bills using condition code 20 when requested by beneficiaries. Traditionally, hospices are the only other category of providers that have received specific guidance from FIs/RHHIs on using this type of demand bill. FIs/RHHIs perform review of such bills, for reasons such as medical necessity, coverage and payment liability issues, although inpatient hospital bills (TOB 11x) are sent to the quality improvement organizations (QIOs), formerly the peer review organizations (PROs), for medical necessity determinations exclusively.

However, for other outpatient billing, this is ONLY in cases when an ABN is not given/not appropriate (for ABN instructions, see §60.4.1 below). Also, services that the provider is sure are noncovered, such as statutory exclusions outside a recognized Medicare benefit, should never be demand billed through this process UNLESS specifically requested by a beneficiary (i.e., the beneficiary wants a determination, not just billing for denial). Either interim bills, final bills or adjustment requests may be used to demand bill.

Other covered services may appear on these claims, but not other noncovered charges, as all noncovered charges on demand bills will be considered in dispute and in need of review. Allowing covered and noncovered services to come in on demand bills will allow all services provided in the statement covers period to be billed, though payment of the covered services will be delayed by the review and development of the noncovered charges. For this reason, providers should break out demand billed services to separate claims for discrete time periods with all noncovered charges whenever possible. Such claims must contain at least one noncovered charge at issue, or the claims with condition code 20 will be returned to the provider.

Funds may be collected from beneficiaries in advance of the determination of liability resulting from medical review of a demand bill (note exception for SNFs in §60.3.1.b immediately above). If the result of such review is that the beneficiary is not liable, as when Medicare pays covered charges, any funds collected in advance must be returned.

Additionally, providers may not collect funds from beneficiaries or subsequent insurers for services for which they know they will be found liable. That is, demand billing cannot be used as a red herring to hold or retain either beneficiary or subsequent insurer funds for any period of time when the provider has reason to know they are fully liable for the services in question.

In summary, other general requirements for demand bills, other than SNF and HH PPS demand bill exceptions, are:

- *Condition code 20 must be used;*

- *All charges associated with condition code 20 must be submitted as noncovered, all noncovered services on the demand bill must be in dispute, and at least one noncovered line must appear on the claim, but unrelated covered charges must be allowed on the same claim (unrelated noncovered charges not in dispute, if any, would be billed on a no payment claim using condition code 21 for outpatient bill types—see III. B. above);*

- *Frequency code zero should be used if all services on the claim are noncovered;*

- *Conditions codes 20 and 32 (i.e., ABN) are NEVER submitted on the same claim; and*

- *Basic required claim elements must be completed.*

Claims not meeting these requirements will be returned to providers. Unlike entirely noncovered outpatient claims using condition code 21, no claims may be submitted simultaneously with demand bills, EXCEPT no payment claims for outpatient bill types using condition code 21, with statement period equal to or fitting within the demand bill statement period. This is true even if only charges associated with the condition code 20 are submitted on the claim, and therefore it is an entirely noncovered claim. No payment bills using condition code 21 are only used for services that are not in dispute, as opposed to noncovered charges on demand bills. This restriction is required because some services on demand bills may be found covered upon review, unlike no payment claims where there is no expectation of coverage/payment. Avoiding overlaps with other than entirely no payment claims will also prevent rejection as duplicates. If received, the incoming overlapping claim using condition code 20 will be processed to completion as a rejection, with a unique reason code explaining the reason for the rejection. Providers can then correct and re-submit the claim assuming the overlap in periods was a billing error.

Also new with this instruction, providers should be aware CMS may require development of any noncovered charge on traditional demand bills. In addition to this review, such services will then be paid, RTP'ed, rejected or denied in accordance with other instructions/edits applied in processing to completion.

60.3.3 - Summary of Methods for Demand Billing

(Rev. 133, 04-02-04)

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 bill be submitted (i.e., for a service excluded by statute)	*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 (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 (131-L --lab services only; and 131-G -- all other services) NOTE: 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 - Noncovered Charges on Outpatient Bills

(Rev. 133, 04-02-04)

The term "outpatient" is often used very generally. In this section, the term should be applied to benefits that are both: (1) Not exclusively inpatient, and (2) Not Part A TOBs (i.e., not TOBs11x, 18x, 21x, 41x). Therefore, "outpatient" here includes inpatient Part B (TOBs 12x, 22x) and hospice (TOBs 81x, 82x).

TABLE 6:

Definition of Fee-for-Service (Traditional or Original) Medicare
Inpatient and Outpatient Services by Bill Type

Concise/General Policy Description: *An inpatient service requires a beneficiary reside in a specific institutional setting during treatment. An outpatient service is provided by an institutional provider, but beneficiaries are not necessarily confined to a specific institution for periods of 24 hours or more.*

Concise/General Claims/Systems Definition: The use of the category terminology is understood to reference the specific listed bill types, EXCEPT general use of the term outpatient is generally understood as all bill types EXCEPT those defined as inpatient Part A. Specific trust fund payment is associated with these bill types. Note an "x" represents a varying third digit in the bill type not needed to identify the benefit.

Category	***Medicare FFS Bill Types (All Types Listed)***	***Trust Fund Payment***
Inpatient Part A	*11x – Hospital* *18x – Swing Bed* *21x – Skilled Nursing Facility (SNF)* *41x – RNHCI – Religious Non-Medical Health Care Institution*	*Part A only*
Inpatient	*12x – Hospital*	*Part B only*
*Part B**	*22x – SNF*	
*In/Outpatient Part A**	*81x, 82x – Hospice*	*Part A only*
*Outpatient**	*13x, 14x – Hospital* *23x – SNF* *34x – Home Health (not prospective payment (PPS))* *71x – RHC – Rural Health Clinic* *72x – RDF – Renal Dialysis Facility* *73x – FQHC – Federally Qualified Health Center* *74x – ORF – Outpatient Rehabilitation Facility* *75x – CORF – Comprehensive ORF* *76x – CMHC – Community Mental Health Center* *83x – Hospital Outpatient Surgery*[1]	*Part B only*

[1]Subject to Ambulatory Surgery Center (ASC) payment limits

[2] Notice of Election, which creates a benefit period in Medicare systems (Common Working File) against which utilization or payment can be tracked; this is the only type of NOE that requires a specific character in the second digit of the bill type, aside from requirements for the frequency cod (third digit).

Category	*Medicare FFS Bill Types (All Types Listed)*	*Trust Fund Payment*
	85x – Critical Access Hospital (CAH) *= =* *32x, 33x – Home Health (PPS)* *= =* *89x – NOE[2] for Coordinated Care Demonstration*	*= = = = = = = =* *Parts A and B* *= = = = = = = =* *No payment*

** Treated as outpatient in processing unless instructions specify otherwise. Note that for inpatient Part B claims, since 10/2003 HIPAA requires that, when transmitted, these claims conform to inpatient requirements for the institutional 837 claim transaction, though Medicare systems will still process these claims like outpatient transactions when received.*

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

(Rev. 133, 04-02-04)

Now, using an ABN is frequently required, much more often than traditional demand billing, usually when medical necessity for outpatient services is in doubt, or when other issues captured in §1862(a)(1) and §1879 of the Act apply, or when previous covered treatment is to be reduced or terminated within a Medicare benefit. Previous ABN instructions brought about a large change in billing practices, because before these instructions, covered charges were never billed when medical necessity was in doubt.

In using the ABN, beneficiaries select one of several billing options they prefer in the face of the provider's anticipation Medicare will not cover a service. Providers can never pre-select ABN options for beneficiaries, in accordance with existing ABN policy, nor are clarifications on billing related to the ABN in this or other chapters of this manual meant to imply ABN options can be pre-selected.

Claims billed in association with an ABN never use condition code 20 or 21, other than HHPPS and SNF PPS exceptions, *and will be returned to providers if received, but instead:*

- *Must use a claim-level occurrence code 32 to signify all services on the claim are associated with one particular ABN given on a specific date (unless the use of modifiers, discussed below, makes clear not every line on the claim is linked to the ABN);*

- *Must provide the date the ABN was signed by the beneficiary in association with the occurrence code;*

- *Occurrence code 32 and accompanying date must be used multiple times if more than one ABN is tied to a single claim for services that must be bundled/billed on the same claim (i.e., one date for one ABN lab services tied to a R-131-L, another for services tied to a R-131-G, even if the date is the same for both ABNs);*

- *Must submit all ABN-related services as covered charges (note –GA modifier exception, below); and*

- *Must complete all basic required claim elements as for other comparable claims for covered services.*

Again, if an ABN is given, these billing procedures must be used, rather than traditional demand billing. Providers should be aware CMS may require suspension of any claims using occurrence code 32 for medical review of covered charges associated with an ABN. Citations for instructions on the ABN, which include information on when an ABN is appropriate, are given above. If claims using occurrence code 32 remain covered, they will be paid, RTP'ed, rejected or denied in accordance with other instructions/edits applied in processing to completion. Denials made through automated medical review of service submitted as covered are still permitted after medical review, and the FI will determine if additional documentation requests or manual development of these services are warranted. For all denials of services associated with the ABN, the beneficiary will be liable.

The –GA modifier is used when provider must bill services related and not related to a ABN on the same claim. See §60.4.2. below for more information this modifier, but note that in the case when it is used both covered and noncovered service may appear on the ABN-related claim.

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

(Rev. 133, 04-02-04)

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:

Source of the Modifier List	***Modifiers***	***Claims Processing Instructions***	***Definition Source***
HCPCS Modifiers Not Covered or Not Payable by Medicare by Administrative Instruction Attached to Definition	*-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 (Transmittal A-02-129)	*CPT: -25, -27, -50, -52*, -58, -59, -73*, -74*, -76, -77, -78, -79, -91 HCPCS: -CA, -E1 through -E4, -FA, -F1 through -F9, -GA, -GG, -GH, -GY, -GZ, -LC, -LD, -LT, -QM, -QN, -RC, -RT, -TA, -T1 through -T9*	*FI standard systems accept these modifiers for processing on OPPS claims (TOBs: 12, 13, 14) in accordance with HCPCS/CPT definitions, and in accordance with chart below.*	*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*
Modifiers Used in Billing Ambulance Noncovered Charges (Transmittal A-02-113, new instructions below)	*-GY, -QL, -QM or -QN, -TQ, alpha destination modifiers*	*Applicable TOBs for ambulance billing: 12x, 13x, 22x, 23x, 83x, 85x*	*See ambulance instructions (III. I.) and chart immediately below*

Source of the Modifier List	***Modifiers***	***Claims Processing Instructions***	***Definition Source***
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 relate to situations where there is no notice requirement, because these charges occur either as treatment begins or after it has started, and Medicare simply reduces the payment to the provider.*

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, and 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 of –KB cannot be used with this code since they requires noncovered

charges. Modifiers most likely to be used with noncovered charges or liability notices are listed below.

TABLE 8:

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

Modi-fier	*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*
-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*

Modi-fier	*HCPCS Modifier Definition*	*HCPCS Coverage/ Payment Admini-strative Instruction*	*Notice Requirement/ Liability*	*Billing Use*	*Payment Result*
-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*
-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 required, 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*

Modi -fier	*HCPCS Modifier Definition*	*HCPCS Coverage/ Payment Admini- strative Instruction*	*Notice Requirement/ Liability*	*Billing Use*	*Payment Result*
-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*
-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, RHHIs 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 theses 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 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. 133, 04-02-04)

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 (transmittal AB-03-057).

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 c~~an~~ 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 Ambulance Claims

(Rev. 133, 04-02-04)

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 after the implementation of this instruction will result in claims being returned. 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. As per previous instructions (CR 1961, Transmittal AB-02-031), 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****	***Liab -ility***	***Billing***	***Remit. Require- ments***	***MSN Message***
STATUTE: Miles beyond closest facility, OR **Pick up point outside of U.S.	***A0888*** *on line item for the noncove red mileage*	***-QM*** *or* ***–QN****, origin/destin- ation modifier****, and*** ***–GY*** *unless condition code* ***21*** *claim used*	*Bene -fici- ary*	*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 responsi- bility, 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 appropri -ate ambulan ce HCPCS*	***–QL*** *unless condition code* ***–21*** *claim*	*Pro- vider*	*Bill mileage line item with* ***–QL*** *as noncovered, line item will be denied*	*Group Code* ***CO*** *for contract-ual obligation, reason code* ***96*** *for*	***16.58*** *"The provider billed this charge as noncovered. You do not have to pay this*

	mileage code (i.e., ground, air)				*noncovered charges*	*amount."; OR, "El proveedor facuró este cargo como no cubierto. Usted no tiene que pagar ests cantidad."*
Subsidy or government owned Ambulance, Medicare NEVER billed***	***A0888** on line item for the noncove red mileage*	***-QM** or **–QN**, origin/destin-ation 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 facuró este cargo como no cubierto. Usted no tiene que pagar ests 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." Origin/destination modifiers, also required by current instruction, combine two alpha characters: one for origin, one for destination.*

*** 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.

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

(Rev. 133, 04-02-04)

Some Medicare preventive benefits are subject to frequency limits, and are also specifically cited at §1862 (a)(1) (F) ff. of the Act as subject to "medical necessity." There has been some confusion as to the basis of denial and how such services are adjudicated. When medical necessity is the basis for denial (i.e., §1862 (a)(1) (F) ff. of the Act), a ABN is necessary in order to shift the liability to the beneficiary, and special ABN-related billing must be used (see III. E. above). Services above frequency limits, however, had been erroneously considered noncovered services by some, and billed as such, not requiring ABNs. In these cases default liability in Medicare systems is the provider, unless specific billing methods and modifiers were used to signal beneficiary liability (see sections III A. and B. above).

Medicare FIs systems had been programmed with frequency as the primary reason for denial at one time, and Medicare carrier systems have used medical necessity. FI systems have changed so that medical necessity is the primary reason for denial.

It may be contrary to provider practices to submit services over the frequency limit as covered charges, as ABN billing requires. However, it can be pointed out that existing Common Working File (CWF) frequency edits should still result in the denial of these services. Remittance denial reason codes and MSN messages to be used in this situation are listed below for beneficiary and provider liability should either circumstance occur:

TABLE 10:

Preventive Benefit	***HCPCS Code(s)***	***PROVIDER LIABLE (ANSI) Remittance Group and Reason Code***	***PROVIDER LIABLE MSN Message***	***BENE. LIABLE (ANSI) Remittance Group and Reason Code***	***BENE. LIABLE MSN Message***
Screening mammography	*G0202, 76092, 76083*	*CO – 57 [57: Payment denied/redu-ced because the payer deems the*	*15.21 The information provided does not support the need for this many services*	*PR – 57* [57: Payment denied/redu -ced because the*	*15.22 The information provided does not support the need for this many*

		information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.]	*or items in this period of time but you do not have to pay this amount. [Le informacion proporciona-da no justifica la necesidad do esta cantidad de servicios o articulos an este periodo de tiempo pero usted no tiene que pagar esta cantidad.]*	*payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.]*	*services or items in this period of time so Medicare will not pay for this item or service. [Le informa-cion proporcio-nada no justifica la necesidad do esta cantidad de servicios o articulos an este periodo de tiempo por lo cual Medicare no pagara por este articulo o servicio.]*

Preventive Benefit	*HCPCS Code(s)*	*PROVIDER LIABLE (ANSI) Remittance Group and Reason Code*	*PROVIDER LIABLE MSN Message*	*BENE. LIABLE (ANSI) Remittance Group and Reason Code*	*BENE. LIABLE MSN Message*
Screening pap smear	*G0123, G0143, G0144, G0145, G0147, G0148, P3000, Q0091*	*CO - 57*	*Ditto above*	*PR – 57**	*Ditto above*
Screening pelvic exam	*G0101*	*CO - 57*	*Ditto above*	*PR – 57**	*Ditto above*
Screening glaucoma	*G0117, G0118*	*CO - 57*	*Ditto above*	*PR – 57**	*Ditto above*
Prostate cancer screening test	*G0102, G0103*	*CO - 57*	*Ditto above*	*PR – 57**	*Ditto above*
Colorectal cancer screening test	*G0104, G0106, G0107, G0120, G0122*	*CO - 57*	*Ditto above*	*PR – 57**	*Ditto above*

* This ANSI ASC X12 reason code becomes obsolete with implementation of the 835 remittance version 4050. For the purpose of this table, use of 57 in the 835 version 4050 and subsequent versions can be crosswalked to code 151: "Payment adjusted because the payer deems the information submitted does not support this many services".

40.6.4 - Bills With Covered and Noncovered Days

(Rev. 133, 04-02-04)

SNF-525, A3-3620

Any combination of covered and noncovered days may be billed on the same bill. It is important to record a day or charge as covered or noncovered because of the following:

- Beneficiary utilization is recorded based upon days during which the patient received hospital or SNF accommodations, including days paid by Medicare and days for which the provider was held liable for reasons other than medical necessity or custodial care.

- The provider may claim credit on its cost report only for covered accommodations, days and charges for which actual payment is made. Provider liable days and charges are not included on the cost report. Data from the bill payment process are used in preparing the cost report.

SNFs show noncovered charges for denied or noncovered days, which will not be paid. The SNF submits the bill with occurrence span code 76 and completes the from/through dates to report periods where the beneficiary is liable. Occurrence span code 77 is used to report periods of noncovered care where the SNF is liable. Occurrence code A3 is used to indicate the last date for which benefits are available or the date benefits were exhausted.

The FI will use Occurrence Span Code 79 (a payer only code sent to CWF) to report periods of noncovered care due to lack of medical necessity or custodial care for which the provider is held liable. Periods of beneficiary liability and provider liability may be reported on one bill. Report all noncovered days.

Where the SNF stay begins as noncovered and ends as covered, only one bill is required. Since the bill will include a covered stay, SNFs complete it fully.

See the Medicare Claims Processing Manual, Chapter 25, "Completing and Processing the UB-92 (CMS-1450) Data Set" for a complete description of Form CMS-1450, electronic formats UB-92, and ANSI X12N data elements. A crosswalk of the form data elements and related format data elements is found in that chapter. See the Medicare Claims Processing Manual, Chapter 30, "Limitation on Liability," for determining SNF liability.

The provider is always liable unless the appropriate *notice is issued*. If the SNF issues the appropriate *notice*, and the beneficiary agrees to make payment either personally or through a private insurer, the days will not be charged towards the 100-day benefit period. *Notice requirements for periods of noncoverage are found in Chapter 30, §70.*

40.6.5 - Notification of Limitation on Liability Decision

(Rev. 133, 04-02-04)

SNF-517.8

Detailed instructions and application of limitation on liability is found in The Medicare Claims Processing Manual, Chapter 30, "Limitation on Liability." The limitation on liability decision is made by the FI when the medical evidence and admission notice, or the bill is submitted. When coverage is denied, notification will be by telephone, if possible, so written notice can be provided to the patient immediately. When it is determined during the course of a beneficiary's stay in an SNF that the care is not covered but both the beneficiary and the SNF are entitled to limitation on liability, the Medicare program may make payment for the noncovered services for a grace period of one day (24 hours) after the date of notice to *the SNF* or to the beneficiary, whichever is earlier. If it is determined that more time is required in order to arrange post-discharge care, up to 1 additional "grace period" day may be paid for.

Limitation of liability may apply to Part A and Part B services furnished by the provider.

40.7 - Other Billing Situations

(Rev. 133, 04-02-04)

A3-3624, A3-3624.B, A3-3630.1, A3-3630.4, A3-3620, HO-411, SNF-517.3, SNF-526.3, SNF-527, SNF-527.1,

A - No Payment Bills

A hospital or SNF is required to submit a bill even though no benefits may be payable. CMS maintains a record of all inpatient services for each beneficiary, whether covered or not. The related information is used for national healthcare planning and also enables CMS to keep track of the beneficiary's benefit period. These bills are known as no-payment bills. A SNF must submit a no-payment bill every month and also when there is a change in the level of care regardless of whether the no-payment days will be paid by Medicaid or a supplemental insurer. When a change in level of care occurs after exhaustion of a beneficiary's covered days of care, the provider must submit the no-payment bill in the next billing cycle.

See the Medicare Claims Processing Manual, Chapter 3, "Inpatient Part A Hospital," §40.4.1, for billing instructions and situations requiring a no-payment bill. See §40.4.2 of the same chapter for FI processing instructions.

Refer to the Medicare Claims Processing Manual, Chapter 25, "Completing and Processing the UB-92 (CMS-1450) Data Set" for further information about billing, as it contains UB-92 data elements and the corresponding fields in the electronic record. Where payment may be made for part of the services, one bill is prepared covering payable **and** nonpayable days and services.

A noncovered bill with condition code 21 indicates a request for a Medicare denial notice. The bill is submitted to obtain a denial notice for Medicaid or another insurer. Do not send a no-payment discharge bill where the patient has Part B entitlement only.

1. *Use of Noncovered Bills with SNFABNs in Cases of Custodial Care under PPS, or Termination of the Benefit during the Spell.*

   *The use of no payment claims/noncovered bills in association with a SNFABN involving custodial care or termination of a benefit during a spell is a clarification of CMS policy. In cases where the SNF plan of care prescribes only custodial care, or if the inpatient benefit has terminated during a spell, **AND** the physician, beneficiary and provider are all in agreement the benefit has terminated or does not apply, SNFs can use the following procedures **instead of traditional demand billing**:*

   a. *The SNFABN for notification of the beneficiary, selecting Option 1 on that form; **and***

   *b. A condition code 21 no payment claim to bill all subsequent services when no **covered** charges have accrued for the monthly billing cycle.*

NOTE: *Providers can never pre-select ABN options for beneficiaries, in accordance with existing ABN policy. In each case, the beneficiary must choose the option they want to select. The ABN option presented relative to the specific billing scenario above, is only an illustration, and not an authorization for pre-empting a beneficiary's right to choose a specific option.*

General instructions for the preparation of no payment claims can be found in §60.1.3, Chapter 1 of the Medicare Claims Processing Manual.

B - Demand Bills

SNF-526, SNF-526.1, A3-3630.1, SNF-526.2, A3-3630

Where the SNF believes that a covered level of care has ended but the beneficiary disagrees, they report occurrence code 21 (UR Notice Received) or 22 (active care ended) as applicable and condition code 20 indicating the beneficiary believes the services are covered beyond the occurrence date. The SNF reports the days and charges after the occurrence code 21 or 22 date as noncovered.

See the Medicare Claims Processing Manual, Chapter 1, "General Billing Requirements," §60, for additional instruction on advance beneficiary notices and demand bills.
Refer to the Medicare Claims Processing Manual, Chapter 25, "Completing and Processing the UB-92 (CMS-1450) Data Set," for further information about billing, as it contains UB-92 data elements and the corresponding fields in the electronic record.

C - Request for Denial Notice for Other Insurer

SNFs complete a noncovered bill and enter condition code 21 to indicate a request for a Medicare denial notice. Refer to Chapter 25, " Completing and Processing the UB-92 (CMS-1450) Data Set," for further information about billing, as it contains UB-92 data elements and the corresponding fields in the electronic record.

D - Another Insurer is Primary to Medicare

See the Medicare Secondary Payer (MSP) Manual, Chapter 3, "MSP Provider Billing Requirements" and Chapter 5, "Contractor Prepayment Processing Requirements," for submitting claims for secondary benefits to Medicare. Refer to the Medicare Claims Processing Manual, Chapter 25, "Completing and Processing the UB-92 Data Set," for further information about billing, as it contains UB-92 data elements and the corresponding fields in the electronic record.