Program Memorandum Intermediaries

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

Transmittal A-01-130 **Date: NOVEMBER 1, 2001**

CHANGE REQUEST 1769

SUBJECT: Receipt and Processing of Non-Covered Charges on Other Than Part A Inpatient Claims

This instruction requires the Common Working File (CWF) and fiscal intermediary (FI) standard systems to accept non-covered charges on claims as specified below. This Program Memorandum (PM) does not create any new requirements for providers to report charges not previously reported, but allows such reporting on other than Part A inpatient claims.

Scope of Claims Affected

Section §3604 of the Medicare Intermediary Manual (MIM), Part 3, requires all national uniform billing committee approved input data to be captured for audit trail purposes, in order to pass this data to other payers with whom coordination of benefit agreements exist. This requirement includes non-covered charges. Additionally, the initiatives listed below will result in Medicare systems generating an increased volume of non-covered charges:

- HH PPS demand bills;
- HH PPS consolidated billing (CB), last phase scheduled for January 1, 2002;
- SNF PPS CB, last phase scheduled for July 1, 2002; and
- Enforcement of hospital bundling requirements (inpatient and outpatient).

The initiatives stated above affect the following types of bills:

12x	**32x**	**72x**	**81x**
13x	**33x**	**73x**	**82x**
14x	**34x**	**74x**	**83x**
22x	**52x**	**75x**	**85x**
23x	**71x**	**76x**	

For demand bills, billing for denial, and other reporting of non-covered charges, this PM supersedes instructions currently in §3604 of the MIM, Part 3, which state: "For outpatient Part B billing, only charges believed to be covered are submitted in [form locator] FL 47. Non-covered charges are omitted from the bill."

The following chart also explains how to report non-covered charge and total charges using the different claim formats:

Claim Format	Total Charges	Non-covered Charges
UB-92 flat file	Use record type 61 Field No. 11	Use record type 61 Field No. 12
X12 837,version3051 implementation3A.01	2 395 SV203	2 395 SV207
X12 837,version3051 implementation1A.C1	2 375 SV203	2 375 SV207
X12 837,version 4010 (HIPAA)	2400 SV203	2400 SV207
Hard copy UB-92	[Form Locator] FL 47	[Form Locator] FL 48

If providers have an instance in which there are covered and non-covered units for service that could be submitted as a single line item, with this instruction providers will now have to split such submissions into two line items, one with all covered and the other with all non-covered charges.

Requirements for Medicare Systems

Claims with non-covered charges as described above, whether submitted by providers, or resulting from comparison between claims filed with FIs and carriers, or resulting from FI review or medical review, must be forwarded to CWF with appropriate ANSI X-12 (denial) codes, and, if applicable, other payers, by FI standard systems. This must be done for both non-covered charges on otherwise covered claims, and entirely non-covered claims. Standard systems must provide a complete CWF record for these claims, totaling the charges on the CWF input under revenue code 0001 (covered and non-covered). The following types of rejects/denials should not be sent to CWF:

- CWF and FI duplicates;
- CWF rejects for entitlement;
- CWF rejects for claims that overlap risk HMO periods;
- CWF rejects for hospice election periods;
- CWF rejects for A/B crossover edits, and;
- CWF rejects for HH PPS Episodes.

The outpatient CWF records (HUOP and HUHH) have been expanded to create a non-covered revenue line field to accept and pass non-covered 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. Therefore, CWF will utilize non-payment codes in §3624 of the MIM and the Medicare Secondary Payer "Cost Avoidance" codes.

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. When payment is made in full by an insurer primary to Medicare, enter the appropriate "Cost Avoidance" code(s) for MSP cost avoided claims. If FIs identify such situations in development or processing of the claim, adjust the claim data the providers submitted, and prepare an appropriate CWF record.

If you receive a completely non-covered claim without either a condition code 20 or a condition code 21, process the claim through your system. These claims must be processed as provider liable unless the occurrence code is 32 and date is present signifying that an advance beneficiary notice was given to the beneficiary on that date.

This PM does not change your current reject process, except to send a record of the reject to CWF. For denials, annotate with the appropriate remittance advice and Medicare Summary Notice or EOMB messages. This applies to the following situations:

- All services are bundled, such as therapy HCPCS 97010;
- All the lines on the claim are packaged;
- The claim is cost avoided; and
- Any other situation which you reject/deny the claim as a result of edits in your standard systems.

(These changes must be made by your standard systems and these rejects sent to CWF.)

If you receive an adjustment request for claims processed prior to implementation and after October 1, 2000, use this new procedure and send the resultant debit (or cancel) to CWF.

No new edits are required by this instruction, but edits currently resulting in the return of claims with non-covered charges to providers must be deleted from the FI standard systems, CWF, and NCH. All Pricers will continue to receive and process only covered line items. CMS expects standards systems to make appropriate accommodations to ignore OCE edits for lines with non-covered charges.

The NCH will assure all non-covered charges, including those for inpatient claims, will be received with valid revenue codes, but clearly indicated as non-covered.

Contractor Workload

FIs *may* experience an increase in workload reporting at the implementation date of the PM. This impact could be immediate for FI claims processing systems, and may affect FIs after duplicate payment edits are installed.

The *effective date* for this PM is dates of service on or after October 1, 2000, received on or after the implementation date.

The *implementation date* for this PM is April 1, 2002 *(prior to implementation of CRs 1794 and Phase 2 of SNF Consolidated Billing)***.**

These instructions should be implemented within your current operating budget.

This PM may be discarded after April 1, 2003.

If you have any questions, contact Cindy Murphy at 410-786-5733 or Antoinette Johnson at 410-786-9326.