Medicare Claims Processing Manual

Chapter 21 - Medicare Summary Notices

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(Rev. 295, 09-03-04)

(Rev. 298, 09-10-04)

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10 - General Medicare Summary Notices (MSN) Requirements

(Rev. 1, 10-01-03)

PMs A-97-8, AB-98-31, A-97-8, B-98-4, A-99-48, A-00-95, B-00-72, AB-01-23

Effective July 1, 2002, the MSN is used by all carriers and intermediaries.

The MSN is the primary vehicle by which beneficiaries are notified of decisions on their claims for Medicare benefits. The intermediary or carrier mails a single MSN at the end of the month to each beneficiary for whom a claim was processed during the month to inform the beneficiary of the disposition of all claims. To ensure that all messages are uniform throughout the Medicare program, intermediaries and carriers may not use locally developed MSN messages until approved by the CMS Regional Office (RO).

MSNs are not sent to providers. Providers receive remittance advice records. (See Chapter 22 for instructions about the provider remittance record.)

The MSN contains the following sections or areas:

- Disclaimer;
- Title;
- Claims Information;
- Message; and
- Appeals.

Detailed requirements for completion of each section are included in §10.3. Generally, carrier and intermediary requirements are the same. Where there are differences or where the specific specification applies to only the carrier or to only the intermediary, the difference is noted in the specific instruction.

Although every attempt has been made to make the MSN as simple as possible, the MSN is sufficiently complex that contractors must maintain continuing training efforts directed at beneficiaries and providers for understanding and interpretation of data on the MSN. Although providers are not mailed copies of MSNs, beneficiaries frequently show MSNs to providers to establish deductible status for provider billing.

10.1 - General Requirements for the MSN

(Rev. 1, 10-01-03)

A3-3726, PM A-99-48, PM A-01-54, B3-7000

A - Intermediary/RHHI MSN

The MSN is used to notify Medicare beneficiaries of action taken on intermediary processed claims. MSNs are not used by RHHIs for RAPs, and RAP data are not included on the monthly MSN.

The MSN provides the beneficiary with a record of services received and the status of any deductibles. The MSN also informs the beneficiary of appeal rights. The Balanced Budget Act of 1997 requires all Part A Benefit notices to include the amount of Medicare payment for each service. Intermediaries and carriers (including RHHIs and DMERCs) must furnish an MSN to all beneficiaries for whom claims are filed during the month unless the situation is specifically excluded by other manual instructions.

The MSN replaced the following documents:

- Form CMS-1533, Part A Medicare Benefit Notice, also known as the Part A Notice of Utilization (NOU) sent for inpatient services;
- Form CMS-1954, Benefit Denial Letter (BDL), sent for partially denied claims; and
- Form CMS-1955, BDL sent for totally denied claims.

Since CMS eliminated BDLs, Medicare beneficiaries receive the information previously conveyed on BDLs through narrative messages contained on the MSN. Providers no longer receive a separate written notification or copy of the BDL. Providers must utilize the coding information (e.g., ANSI Reason Codes) conveyed on the financial remittance advice to ascertain reasons associated with Medicare claims determinations affecting payment and applicable appeal rights and/or appeals information.

B - Carrier/DMERC MSN

The MSN is used to notify Medicare beneficiaries of action taken on their processed claims. The MSN provides the beneficiary with a record of services received and the status of any deductibles. The MSN also informs the beneficiary of appeal rights.

10.2 - Correction/Reissuance of Faulty MSNs

(Rev. 1, 10-01-03)

Occasionally programming errors will occur which cause inaccuracies on MSNs that do not materially affect benefits. An example of a potential programming error could be one

data column writing in another data column. So long as the claims are correctly paid and the notice is intelligible, it is not necessary to identify the impacted MSNs or reissue them. The resources to identify and reissue all of the documents would not be justified. In situations where contractors feel reissuance is absolutely necessary, they must work with their regional office to identify costs involved before proceeding. When such problems occur, contractors must take actions that will inform beneficiaries of the situation. These actions should fall within the framework of routine operations. Such actions include, but are not limited to, fielding calls from beneficiaries and alerting customer service representatives of the situation, posting an alert on contractors' local websites, adding a message to IVR script, etc. While not all of these solutions may be possible, contractors should take the most appropriate steps to best mitigate the potential confusion, but not incur special costs. Any communication regarding this type of situation should convey that it was a temporary programming error, which has been fixed, and is believed not to have affected the beneficiary's benefits.

A beneficiary may call the contractor to request a copy of the MSN with the correct information. In such cases, the contractor will provide one.

10.3 - Carrier and Intermediary Instructions for Preparing the MSN

(Rev. 1, 10-01-03)

PM A-99-48

10.3.1 - General Requirements - MSN

(Rev. 1, 10-01-03)

A3-3726.1, AB-98-31

The MSN is specifically designed as a summary notice to beneficiaries. Providers receive a summary voucher and check. Intermediaries send MSN notices to beneficiaries for outpatient and inpatient claims combined in one notice every month. Carriers send notices to beneficiaries for assigned claims and unassigned claims with no payment to the beneficiary once every month. Carriers send notices for unassigned claims and assigned claims with payment due to the beneficiary as they are processed or according to their present schedule.

When requested by the quality assurance (QA) staff, contractors produce an exact copy of the MSN sent to the beneficiary for QA reviews. If the beneficiary requests a replacement copy, the contractor must be able to produce an exact copy as it was originally generated or produce an MSN containing only the claim requested by the beneficiary, even though it may have been part of a summary. The beneficiary's request will determine the type of copy that the contractor sends.

Copies for claims processed prior to the MSN format can be produced in the MSN format. Contractors must also generate an MSN upon beneficiary request for previously suppressed claim information.

Contractors must have the capability to issue the MSN in Spanish, if the beneficiary requests this. To assess beneficiary preference for a Spanish MSN, contractors may print a message in the General Information section in both Spanish and English which tells beneficiaries that they can receive the MSN in Spanish if they desire, or they may use an Automated Response Unit (ARU) for beneficiaries to request a Spanish MSN.

Contractors also:

- Generate by computer the entire front of the form; and
- Preprint or generate by computer the back of the form.

To the extent that contractors have the capability to perform duplex printing, they must exercise that option.

To ensure all claims processing messages are uniform throughout the Medicare program, contractors do not use locally developed claims processing messages until approved and assigned a number by CMS Central Office (CO). Contractors send draft claims processing messages for preliminary review to their RO along with an explanation of necessity. Regional offices now have the authority to approve local General Information and "Help Stop Fraud" messages.

Carriers and intermediaries are required to include a "Help Stop Fraud" message every six months.

Language must be approved by the RO. Contractors send draft messages for review to their RO along with an explanation of necessity. The RO will review the messages and respond.

The "Help Stop Fraud" section is designed for varying "Help Stop Fraud" messages, which can be found in §50.24, and/or to alert beneficiaries of local fraud scams. For example, if a contractor knows of someone offering free cheese and milk in exchange for Medicare numbers, it can design a message telling beneficiaries to be extra careful. Since space is limited in the "Help Stop Fraud" section, the contractor can use the "General Information" section for lengthy messages. If it uses those messages provided in §50.24, it should review its message every six months to determine if a more appropriate message could be used. "Help Stop Fraud" messages may be changed as often as necessary, as long as they are timely and current. Messages that pertain to local fraud scams need only be approved at the RO level. General "Help Stop Fraud" messages that contractors develop, similar in content to those listed in §50.24, must be approved by CMS.

The "General Information" section is designed to inform beneficiaries of local health fairs and Medicare seminars, as well as those messages in §50.24, and those mandated by CMS. Messages that pertain to local events need be approved only at the RO level.

"General Information" messages that carriers develop, similar in content to those listed in §50.24, must be approved by CO through the RO.

Sample exhibits are provided in §50.24. These samples are referenced throughout the text. In the event of a discrepancy, the written instructions take precedence over the exhibits.

10.3.2 - Basic Concepts and Approaches

(Rev. 1, 10-01-03)

A3-3726.2, B3-7003

The MSN is the notice to a beneficiary that displays data for claims processed during the reporting period. The MSN lists claim information in a summarized format.

Each MSN consists of the following sections:

- Disclaimer Section;
- Title Section;
- Claims Information Section;
- Message Section; and
- Appeals Section.

For technical specifications, refer to §10.3.4.

Contractors use bar coding to obtain Postal Service discounts. If their system permits, and multiple MSNs are available for mailing, they enclose all MSNs in the same envelope.

One MSN should be produced for Part B outpatient claims with services furnished in different calendar years. However, the "Deductible Information" section should contain the appropriate deductible information for each calendar year represented on the MSN. Similarly, MSNs with Part A inpatient claims for services furnished in more than one benefit period should contain deductible information for each benefit period reflected on the MSN.

If a contractor is mailing payment to the beneficiary for more than one claim, it combines all payments to the beneficiary in one check and provides check summary information. MSNs with payment to the beneficiary should include a check in the same envelope.

The name and address of the billing provider includes provider name and complete mailing address. Below the billing provider name and address, if applicable, the contractor shows "Referred by:" then gives the full name of the attending physician.

Claims should be displayed by billing provider in alphabetical order.

For multiple claims from one billing provider, the claims are sorted on the notice chronologically by date of service.

Intermediaries use revenue code standard abbreviations provided by the National Uniform Billing Committee without changing the wording.

If HCPCS codes are shown, intermediaries use the short description of services provided by CMS. If the HCPCS code descriptor is used, intermediaries do not show the revenue code descriptor.

MSNs are a combination of fixed and variable length sections. There are blocks around the "Claim Information" and "Notes" sections, which are variable in size. Contractors establish page breaks as specified by these instructions and exhibits.

10.3.3 - Format for the MSN

(Rev. 1, 10-01-03)

A3-3726.3, B3-7004

The carrier or intermediary must follow these instructions:

- Generate all MSN forms by a laser printer.
- Ensure that the MSN is printed on 8 1/2 by 11 inch paper, exclusive of perforated marginal pin-feed tabs.
- Use "equivalent to" point sizes in the specifications.
- Use upper and lower case letters as well as bold printing throughout the form. With the exception of the beneficiary name and address (and dollar amounts, if necessary), print all information using proportional fonts similar to the Times New Roman fonts used in the exhibits.
- Print beneficiary master file information (e.g., beneficiary name and address) in upper case letters to conform to postal regulations.
- Print dollar amounts in fixed pitch font if unable to use proportional font.
- Print billing provider name(s) and mailing address(es) in bold mixed case. If the contractor does not store the provider information in mixed case, it may print in all uppercase.
- Use black ink on white paper. Use shading as required by the instructions and exhibits.

- Print the front and back of the MSN at no more than 6 lines to the inch.
- Allow for coding necessary for mail sorting equipment (e.g., bar coding, aims marks).
- Ensure any contractor's notations placed on the MSN do not affect the design of the MSN.
- Refer to the specifications and exhibits for placement of information on the MSN.

10.3.4 - Technical Specifications for the MSN

(Rev. 1, 10-01-03)

A3-3726.4, B3-7006

This information explains the display in specific areas of the notice and describes the technical specifications to be used in producing MSNs. The font should be consistent throughout the notice, and should be similar to the Times New Roman font. Contractors are to use 1/2-inch outer margins on the notice.

General Information about Disclaimer:

- Print equivalent to 15-point bold all caps at the bottom of the first page, "THIS IS NOT A BILL."
- Directly following this, print equivalent to 15-point upper and lower mixed case: "Keep This Notice For Your Records."
- Contractors print a dash between "THIS IS NOT A BILL" and "Keep This Notice For Your Records" with a blank space on each side of the dash.
- This information should be centered.

10.3.5 - Title Section of the MSN

(Rev. 1, 10-01-03)

A3-3726.5, AB 98-31, B3-7006.1, PM-AB-02-106

A - General Information about the "Title" Section

This section contains a fixed display of information. It does not vary in length. It contains the following elements:

- Title of notice;
- Beneficiary name and mailing address;

- "Be Informed" statement; and
- Customer Service Information including:
    - Beneficiary Medicare number;
    - Contractor's mailing address;
    - Local telephone number;
    - Toll free telephone number, if available;
    - TTY telephone number; and
    - "Summary of Claims Processed" statement.

NOTE: Contractors have the option of changing the type of information in the Customer Service Information box. For example, they may choose to list the phone number of the appeals department. At a minimum, however, they must still include the contractor's address, a local and toll free phone number (where there is one), and a TTY number (where there is one.) There must be one blank line between the address and phone numbers. All changes must be approved by each contractor's RO. The RO will notify CO of the approved change.

B - Technical Specifications for "Title" Section

Details of the technical specifications for each element in the title section follow.

Title of Notice

"Medicare Summary Notice" is printed in mixed case equivalent to 30-point bold type. The title is centered within a box of 10-percent shading. The box extends from left margin to right margin. In the left corner of the box, the CMS logo (imported) is printed. In the upper right hand corner of box "Page 1 of __" is printed in mixed case equivalent to 10-point type.

In the bottom right hand corner of the title box, the date the notice was printed is shown in mixed case equivalent to 10-point type.

Then a blank line equivalent to 10-point type occurs.

Beneficiary Name and Mailing Address

The beneficiary name, mailing address, and dollar amounts are printed in all uppercase letters equivalent to 10-point size fixed pitch font (the font may not be script, italic or any other stylized font). The name and address information is placed as shown in exhibits to conform to U. S. Postal Regulations. (The beneficiary name, mailing address, and dollar

amounts are the only data elements that may be printed in fixed pitch fonts. The rest of the MSN is printed using proportional fonts.)

Contractors are not to change the format of the "Title" section in order to use double window envelopes. Include a separate mailing sheet with both a return and delivery address for double window envelopes.

Customer Service Information (refer to note in A above)

Print a box equivalent to a 1-point line around the following customer service information. Extend from center of page to the right margin. Height is 2 1/2 inches. Width is 3 1/2 inches.

- Allow equivalent to 12-point blank line.
- Print "Customer Service Information" in upper case equivalent to 12-point bold type.
- Print "Your Medicare Number: _____" centered in the box equivalent to 12-point bold mixed case.
- Print "If you have questions, write or call:" in mixed case equivalent to 12-point type.
- Indent 4 bytes and print the contractor's mailing address on the next 5 lines equivalent to 12-point type.
- Allow equivalent to 12-point blank line.
- Indent 4 bytes and print "Local:" then the contractor's local telephone number to include area code, in mixed case equivalent to 12-point bold type.
- Indent and print "Toll free:" then the toll free telephone number in mixed case equivalent to 12-point bold type. If the contractor does not have a toll free number, replace it with a blank line.
- Indent and print "TTY for Hearing Impaired:" then the contractor's TTY number in mixed case equivalent to 12-point type. If the contractor does not have a TTY number, replace it with a blank line.

Be Informed Statement

- Print "Be Informed:" in upper case letters and bold equivalent to 12-point type. Begin printing the fraud message on the same line as "Be Informed:" Print the fraud message in mixed case equivalent to 12-point type. It may continue for 2 additional lines. Fraud messages are found in §50.24. Print only those messages approved for the "Be Informed" section. The "Be Informed" section should end no lower than the bottom of the "Customer Service Information" box. There

should be at least 2 bytes between the end of each line and the beginning of the “Customer Service” box.

- Allow equivalent to 12-point blank line.

- For intermediaries, on all notices processed for services on multiple days, print “This is a summary of claims processed from mm/dd/yyyy to mm/dd/yyyy.” in mixed case equivalent to 14-point type centered between the margins. For all notices for services processed on a single day, print “This is a summary of claims processed on mm/dd/yyyy.” in mixed case equivalent to 14-point type centered between the margins.

- Allow equivalent to 18-point blank line.

- For carriers, for unassigned and assigned claims with no payment to the beneficiary, and with different finalization dates, print “This is a summary of claims processed from mm/dd/yyyy through mm/dd/yyyy” in mixed case equivalent to 14-point type centered between the margins.

- For carriers, for unassigned and assigned claims with no payment to the beneficiary and the same finalization dates, print “This is a summary of claims processed on mm/dd/yyyy in mixed case equivalent to 14-point type centered between the margins.”

- For unassigned and assigned claims with payment to the beneficiary, print “This is a summary of claims processed on mm/dd/yyyy in mixed case equivalent to 14-point type centered between the margins. The mm/dd/yyyy inserts should be high/low claim finalization dates.”

- Allow equivalent to 18-point blank line.

10.3.6 - Claims Information Section

(Rev. 1, 10-01-03)

B3 7006.2, PM A-00-36

A - General Information About the “Claims Information” Section

The claims information section contains the following elements:

- For Intermediaries:

    - Program Status Line ("Part A Hospital Insurance - Inpatient Claims” or “Part B Medical Insurance - Outpatient Facility Claims” or “Home Health Facility Claims” or “Hospice Facility Claims"

    - Column Headings

- Claim Number
- Provider's Name and Address
- Attending/referring Physician's Name
- Service Line Details
- Claims Totals
- Alphabetic Codes for "Notes"
- The name and address of the billing provider includes the provider's name and complete address. Below the billing provider's name and address, if applicable, show "referred by the full name of the attending physician.
- Claims should be displayed by billing provider in alphabetic order.
- For multiple claims from one billing provider, sort claims chronologically by service
- Use standard abbreviation of Revenue Codes provider by the National Uniform Billing Committee and do not change wording.
- If HCPCS are shown, use short description of services provided by CMS. If the descriptor is used, do not show the revenue code descriptor.

- For Carriers - Part B Medical Insurance:

  Except for the header and the provider name(s) and address(es), which are fixed, the data in Area II can vary in length. Area II contains the following elements:

  - Control number(s),
  - Provider name(s) and address(es),
  - Service or line item detail, and
  - Alphabetic note codes.

B - Technical Specifications for "Claims Information" Section

For Intermediaries:

Program Status Line

- For inpatient claims print "PART A HOSPITAL INSURANCE - INPATIENT CLAIMS" in uppercase equivalent to 12-point bold type;
- For outpatient claims, print "PART B MEDICAL INSURANCE - OUTPATIENT FACILITY CLAIMS" in uppercase equivalent to 12-point bold type;

- For Home Health Part A claims, print “PART A - HOME HEALTH FACILITY CLAIMS”;

- For hospice claims, print “Part A - HOSPICE FACILITY CLAIMS.”

Allow equivalent to 10-point blank line.

Print a box equivalent to a 1-point line around the following claims information. The box will be variable in length depending on the number of claims displayed. There is a 1-byte margin between the claims information box line and the beginning and ending of printed information. There is a 1-byte space between columns. Print the column headings in mixed case type, equivalent to 10-point bold type, using 3 lines as in the exhibits.

Dates of Service - The “Dates of Service” column is 17 bytes wide. Center the column heading within the first 7 bytes.

Services Provided - Use for outpatient claims only. The “Services Provided” column is 45 bytes wide. Print the column heading flush left in the column.

Number of Services Provided - Use for Home Health claims. The “Number of Services Provided” column is 45 bytes wide. Print the column heading flush left in the column.

Benefit Days Used - Use for inpatient claims only. The “Benefit Days Used” column is 11 bytes wide. Print the column flush right.

Amount Charged - Used for Outpatient and Home Health Claims Only - The “Amount Charged” column is 11 bytes wide. Print the column heading flush right in the column.

Noncovered Charges - The “Noncovered Charges” column is 11 bytes wide. Print the column heading flush right in the column.

Deductible and Coinsurance - Used for Inpatient and Outpatient Claims - The “Deductible and Coinsurance” column is 10 bytes wide. Center the column heading. (For Home Health claims, the title is “Coinsurance").

You May Be Billed - The “You May Be Billed” column is 10 bytes wide. Center the column heading.

See Notes Section - The “See Notes Section” is 7 bytes wide. Center the column heading.

Print a horizontal equivalent to 1-point line extending from left to right margin between the column headings and the claim(s) information.

Allow equivalent to 10-point blank line.

Print claim information within the box as follows:

- The claim number spans the “Dates of Service” and “Services Provided” columns. Do not extend information into the “Amount Charged” column.
    - Print “Claim number” in mixed case equivalent to 10-point mixed case followed by the actual claim number on the line directly above the provider name and address.
- The provider information spans the “Dates of Service” and “Services Provided” columns. Do not extend information into the “Amount Charged” column.
    - Print the billing provider name and mailing address in mixed case equivalent to 10-point bold type. Billing provider name and address should be separated by commas. Use the physical address of the billing provider if it is different from the mailing address. If possible, print this information on one line. Additional lines, if necessary, should be indented five bytes. For carriers, when using degree (e.g. M.D.) with provider name, place a period after the “M” and after the “D.”
    - Print “Referred by:” followed by the attending physician’s name and degree (if applicable) in mixed case equivalent to 10-point type. When printing degree (e.g., M.D.) with provider name, place a period after the “M” and after the “D.” Referring physician name and degree should be separated by a comma. If the UPIN submitted on the claim is not on file, use the name as shown on the claim. Suppress the “Referred by:” line if not able to identify the doctor. For carriers, if the referring physician is the same as any performing physician on the claim, suppress the referring physician line. If the UPIN submitted on the claim is not on the contractor’s file, suppress the “Referred by:” line. For clinic or group practice billing, print the performing physician’s name in mixed case equivalent to 10-point type immediately before the services the physician performed.
- Dates of Service - Print service line dates in mm/dd/yyyy format in “Dates of Service” column in mixed case equivalent to 10-point type, left justified. If services extend over several days, use a hyphen or dash to show the extension (mm/dd/yyyy - mm/dd/yyyy).
- The “Services Provided” column contains the HCPCS short descriptor in mixed case equivalent to 10-point type followed by code in parenthesis or revenue code descriptor. If no HCPCS code is present, show the revenue code standard abbreviation as defined by the National Uniform Billing Committee, left justified (bytes 1-47 are reserved for these descriptions). Print each service description on no more than 1 line, on the same line horizontally as the date of service.
- Number of Services Provided - The “Number of Services Provided” column is the revenue code standard abbreviation as defined by the National Uniform Billing

Committee, preceded by the number of units, both of which are in mixed case to 10 point type. If a HCPCS code is present, the HCPCS short descriptor will be used. Left justify (bytes 1-45 are reserved for this element). Print each "Number of Services Provided" in no more than one line, on the same line horizontally as the "Date of Service."

- Benefit Days Used - This column will show the number of days used during the hospital or skilled nursing facility admission (i.e., 12 days) Use case equivalent to 10 point type. Left justify (bytes 1-11 are reserved for this). Print each "Benefit days Used" in no more than one line on the same line horizontally as "Date of Service."

- Align all dollar amounts appearing in the "Claim Information Box" by decimal. For zero dollar amounts, show "0.00." Print all dollar amounts in mixed case equivalent type.

- Amount Charged - Show the submitted charge for each service line. Print a dollar sign on the first service line. Right justify all charges. This detail is not shown on Part A inpatient (hospital or SNF) claims. Print in mixed case equivalent to 10-point type.

- Noncovered Charges - Show the noncovered amount for each service line. Print a dollar sign on the first service line. Right justify all charges. Noncovered services will include beneficiary liable as well as provider liable charges.

- Deductible and Coinsurance - Show the "Deductible and Coinsurance" applicable for each service line. Print a dollar sign on the first service line. Right justify all amounts. Carriers show deductible and coinsurance with a message in the "Notes" section.

- You May Be Billed - Show the beneficiary liability for each service line. Print a dollar sign on the first service line. Right justify all amounts. Print in mixed case equivalent to 10-point type.

- See Notes Section - Enter lowercase "a" for the first item that requires an explanation. Place "a" and the appropriate message from §50 in the "See Notes Section" box. If the same message is needed for more than one claim or service line, print the same alphabetic code each time the message is required on the MSN. Print alphabetic codes in mixed case equivalent to 10-point type.

    - If the contractor's system provides a second message for the same item, print the letter "b" in lowercase equivalent to 10-point type preceded by a comma. Show no more than three alphabetic codes per line.

    - For all remaining claims on the MSN, if a claim or service line requires a message, use the next available lowercase alphabetic code.

- Print alphabetic codes for claim level notes in bold in the "See Notes Section" column on the same line as the billing provider's name. The next 3 codes will be directly below the first 3, which places them on the same line as the billing provider's street address. Print alphabetic codes for service lines in the "See Notes Section" column on the same line as the service. If more than 3 codes for line level, print on the next line below. Print alphabetic codes flush left. If more than 26 lower case alphabetic codes are used, begin using uppercase alphabetic codes.

- Claim Total Line - Indent 12 bytes and print in mixed case type equivalent to 10-point bold "Claim Total." Print the "Claim Total" line only for claims with more than one service line.

  - Total the amounts in each column and print the sum right justified and equivalent to 10-point bold type. Print a dollar sign preceding the total in each column. The total amount in the "Medicare Paid You" column includes all interest paid to the beneficiary for that claim.

- Print a horizontal line 1/16-inch wide in 20 percent shading extending from left to right margin on the claim information box. Print this shaded line between each claim shown on the MSN. Do not print the shaded line under the last claim displayed in the "Claims Information Section." Do not print the shaded line if only one claim is displayed on the MSN.

For Carriers:

Carriers print in the following order:

1. Horizontal line (0.048" wide extending from left to right margin).

2. In 10 point bold type, show "Details about this notice. (See the back for more information.)" Print this text in 10% shading.

3. Horizontal line (0.008" wide extending from left to right margin).

4. Display the provider name(s) and address(es), control number(s) (break control numbers into segments (see sample)), headings, and service detail according to the rules described below. The length and appearance of the service display will vary according to whether the EOMB is for an assigned or unassigned claim. Print all of this information in 10 point type and bold where indicated.

   For assigned claims (one billing provider, possibility of multiple control numbers), print, under the horizontal line, the following information in this order:

   - "BILL SUBMITTED BY:", in all uppercase letters in 10 point bold type;

- On the same line starting one half inch beyond the end of "BILL SUBMITTED BY:", print the name of the provider. When using "M.D." with the provider name, place a period after the "M" and after the "D."
- Directly underneath the words "BILL SUBMITTED BY:" print the words "Mailing address:" Print the address directly underneath the name of the provider and on a single line, if possible.
- If the service was provided at a clinic/group practice that bills for its physicians, show the clinic/group practice name; and
- If a solo practicing physician performed the service(s), show his/her name and complete mailing address.

For clinic/group practice billing, show the performing physician's name as follows:

- Blank line;
- Print the following headings in 10 point bold:
  - Dates;
  - Services and Service Codes;
  - Charge;
  - Medicare Approved; and
  - See Notes Below.

Print the "Dates" heading aligned with the left margin. Print the "Services and Service Codes" heading aligned with the provider name and mailing address. Use appropriate spacing as shown in Exhibits 1, 2, and 3 to print the remaining headings on the same line.

The information printed under each heading is described later in this section.

- Control number in 10 point bold type;
- Performing physician's full name in 10 point bold type;
- Service items for performing physician;
- Blank line;
- If there is only one control number and one provider: after all of the service items have been listed, sum the charged and approved amounts to derive a total. Print a "+" beside the "charge" and "approved" amounts of the last line item and underline. Print "Total" in 10 point bold type face aligned with the left edge of the summary box found in area I and print the totals for the "Charge" and "Medicare Approved" columns. A "$" is printed before each dollar total.

Use the totals of the “Charge” and “Medicare Approved” columns in the summary block in Area I. Also, use the total “Medicare Approved” amount in Area IV.

Suppress “Total” if only one line item appears on the EOMB. There is no need to total one line item.

NOTE: For multiple control numbers and providers, do not follow the directions in number 8. until all control numbers, providers, and service items have been listed. For multiple performing physicians under the same control number, repeat numbers 5., 6., and 7. until all performing physicians’ names and service items have been listed. For multiple control numbers, repeat numbers 4., 5., 6., and 7. until the performing physicians names and service items for all control numbers have been printed. After the last provider’s services have been listed for the last control number, sum the charged and approved amounts. Do not leave a blank line between the last service item and the “Total.”

For unassigned claims (one control number, possibility of multiple providers), print, under the horizontal line, the following information in this order:

- Control number in 10 point bold type;
- Blank line;
- "BILL SUBMITTED BY:”, in all uppercase letters in 10 point bold type;
- On the same line, one half inch beyond the end of “BILL SUBMITTED BY:”, print the name of the physician/supplier providing the medical service or supplies. Directly beneath the words “BILL SUBMITTED BY:” print the heading: “Mailing address:". Print the mailing address directly underneath the name of the physician/supplier. Print this information in no more than two lines.
- If the service was provided at a clinic/group practice that bills for its physicians, show the clinic/group practice name; and
- If a solo practicing physician performed the services, show his/her name and complete mailing address.

For clinic/group practice billing, show the performing physician’s name immediately before the services he/she performed in 10 point bold type as directed below. If the system does not carry the clinic/group name for unassigned claims, show the performing provider’s name in place of the clinic/group name followed by the clinic/group address.

- Blank line.
- Print the following headings in 10 point bold underlined:
    - Services and Service Codes,

- Dates,
- Charge,
- Medicare Approved, and
- See Notes Below.

Print the "Dates" heading aligned with the left margin. Print the "Services and Service Codes" heading aligned with the provider/supplier name and address. Use appropriate spacing as shown in Exhibits 1, 2 and 3 to print the remaining headings on the same line.

The information printed under each heading is described later in this section.

- Print the performing physician's name in 10 point bold type if the provider is a clinic. List all service items in chronological order for that physician. For each performing physician billed by a clinic, list his/her name in 10 point bold type followed on the next line by the service item(s). Generally there is only one provider. If so, after all of the service items have been listed, sum the charged and approved amounts to derive a total. Print a "+" beside the "charge" and "approved" amounts of the last line item and underline. Print "Total" in 10 point bold type face aligned with the left edge of the area I summary box and print the totals for the "Charge" and "Medicare Approved" columns. Print a "$" before each dollar total.

Use the totals of the "Charge" and "Medicare Approved" columns in the summary block in Area I. Also, use the total "Medicare Approved" amount in Area IV.

Suppress "Total" if only one line item appears on the MSN. There is no need to total one line item.

NOTE 1: For multiple providers (when beneficiaries submit claims, see Note 2), do not print the totals until all providers and service items have been listed. For each provider, print the information shown above for unassigned claims. After the last provider's services have been listed, sum the charge and approved amounts. Do not leave a blank line between the last service item and "Total".

NOTE 2: Unassigned claims are submitted by providers and should, therefore, be one claim to one EOMB. However, produce an EOMB showing multiple providers when beneficiaries have submitted claims. Generate these when:

- Services were provided before September 1, 1990;
- Services were not covered by Medicare and beneficiaries want a formal coverage determination;
- Physicians or suppliers refuse to submit claims for services on or after September 1, 1990;

- Services were provided outside the United States;
- Used DME is purchased from a private source; or
- Medicare is secondary payer.

- Aligned with the left margin, print the following statement in 10 point bold type: "Your provider(s) did not accept assignment. We are paying you the amount that we owe you. See #4 on the back." (NOTE: print this statement on a single line preceded by a blank line). Do not print the "We are paying you the amount that we owe you" portion of the message when no payment is made.

The data printed under each of the headings mentioned above are described here. Print each service, code, date, charge, approved amount and notes on one line.

The "Services Provided" column contains the number of services, HCPCS code short descriptor, procedure code, and modifiers. Print in mixed case equivalent to 10-point type. The first 3 bytes are fixed and reserved for the number of services. Right justify the number of services within these 3 bytes. Byte 4 is a space. Bytes 5 through 47 are reserved for the HCPCS short descriptors, procedure codes and modifiers. Print each service description in no more than 1 line in mixed case equivalent to 10-point type. Follow the descriptor by procedure code, and modifier(s) if necessary, in parentheses. The carrier separates procedure codes and modifiers with a dash.

Print the following modifier descriptors on the next line when applicable. When printing a modifier descriptor, drop the procedure code and its modifier(s) to the line with the modifier descriptor. Begin printing the procedure code directly under the short descriptor. The modifier descriptor should follow immediately after the procedure code.

Services and applicable modification codes and descriptions are shown in the following table.

Service	**Modifier Code**	**Modifier Description on MSN(s)**
Assistant surgery	80, 81, and 82	Assistant surgeon
Professional component	26	Professional charge
Technical component	TC	Technical charge
DME rental	RR	Rental
DME purchase	NR	Purchase
DME maintenance/service	MS	Maintenance/service

Service	Modifier Code	Modifier Description on MSN(s)
DME replacement/repair	RP	Replacement/repair
Post-op care	55	Care after operation
Pre-op care	56	Care before operation
Ambulatory surgical center fees	SG	Surgery center fee

NOTE FOR DMERCS: If there are 3 or more modifiers, drop the procedure code and its modifiers to the next line. Begin printing the procedure directly under the short descriptor. The modifier descriptor should follow immediately after the procedure code.

Dates - Use the first three letters of the month name as a three letter abbreviation for the month. If the services extended over several days or into the following month, use a "-" to show the extension.

Charges - Show submitted charge(s). Print the dollar sign on the first line. After of the service items have been listed, sum the charges to derive a total. Print a "+" beside the charge for the last line item and underline.

Medicare Approved - Show the fee schedule amount or approved charge. For claims involving psychiatric outpatient services, print the approved amount before the psychiatric reduction. Print the dollar sign on the first line. After all of the service items are printed, sum the charges to derive a total. Print a "+" beside the charge for the last line item and underline.

See Notes Below - Print the heading if there are any explanatory notes. Suppress the heading if the MSN does not require notes.

Enter "a" for the first line item which requires explanation. See §30.2 for a list of the notes to be used on the MSN. Place "a" and the appropriate explanation from §30.2 under "Notes." If another line item is reduced or disallowed for the same reason, also print "a" beside this line item. If the system provides a second explanation for this line item, print the letter "b", preceded by a comma. Enter the explanation from §30.2 in the "Notes" section. Show no more than 5 alphabetic codes and notes per line.

Print notes pertaining to a single line by entering the alphabetic code in the "Notes" column to the right of the line. When there is more than one claim on the MSN, print notes pertaining to a single claim to the right of the claim control number. Print notes pertaining to all claims to the right of the "Total" amount.

- Horizontal line (0.018” wide extending from left to right margin). If Area III starts on a subsequent page, do not print this horizontal line.

Align all dollar amounts appearing in Area II by decimal. For zero dollar amounts, show “0.00".

Additional Claims Information Specifications

- The contractor may split a claim between pages if the claim is more than 10 lines long. If there is insufficient space to print at least 5 lines, do not split the claim. Put the claim on the next page.

- If there is a need to continue the “Claims Information Box” past the first page, print the program status line on the top of continuing pages in the upper left corner below the header, followed by “(continued)” equivalent to 12-point bold lower case type.

- Repeat column headings and line specifications according to the preceding instructions.

- Allow 1 equivalent to 12-point blank line between claims information and beginning of notes section.

- (CARRIERS ONLY): If no “Notes” section is printed, the blank line should precede the section that follows. When a single MSN contains both assigned and unassigned claims, each claim type should be displayed in its appropriate box. The boxes should follow directly after each other. Allow one 12-point blank line between the bottom line of the first box and the assignment status line of the second box. Each box should be created following the specifications in this section. When assigning alphabetic codes for the “See Notes Section” column, if the same message is needed in both the assigned and unassigned claims information boxes, print the same alphabetic code each time the message is required. When a claim in the second claims information box requires a new message, use the next available alphabetic code after the last code used in the preceding box.

- The MSN may be split if more than 99 claims are processed in one 30-day period.

- Do not print claims denied as duplicates.

10.3.7 - Message Section

(Rev. 1, 10-01-03)

A3-3726.7, B3-7006.3

A - General Information about “Message” Section

The “Message” section consists of three parts.

- The “Notes” section contains alphabetic codes and messages explaining the claim and service line determinations;
- "Deductible Information” contains messages communicating deductible status for each year of service or benefit period displayed on the MSN; and
- "General Information” contains news of general interest that is issued to all beneficiaries.

B - Technical Specifications for “Message” Section

The following outlines the technical specifications for each element of the “Message” section.

"Notes” Section

- Print a box equivalent to 1-point line around the “Notes” section.
- The length of the “Notes” section varies depending on the number of messages needed. If there are no messages to be printed, suppress the entire “Notes” section.
- Allow a 1-byte margin between the “Notes” section box line and the beginning and ending of printed information.
- Print “Notes Section:” title equivalent to 14-point bold mixed case type. Indent 1 byte and print “Notes Section.”
- Allow equivalent to 12-point blank line.
- Indent the alphabetic code(s) 2 bytes from the margin.
- List the message codes in alphabetic order.
- Print the alphabetic codes equivalent to 12-point lower case type. Print the messages equivalent to 12-point bold mixed case type. Print additional alphabetic codes in upper case equivalent to 12-point type. Print all the messages in mixed case equivalent to 12-point type.

- Allow 2 bytes between the alpha code and the message.
- Indent additional lines of each message 5 bytes from the margin.
- Allow equivalent to 12-point blank line between messages.
- Do not print the “Notes Section” title without at least 1 complete message following it on the same page.
- Do not split messages. Each message must be printed in its entirety on the same page.
- Print “(continued)” equivalent to 12-point bold type in the bottom right corner of the “Notes Section” box when the “Notes Section” box continues onto another page.
- Print the title “Notes Section (continued):” equivalent to 14-point bold mixed case type in the upper left corner of the next page below the header.
- All “Notes Section” boxes should be closed on each page that they appear.
- Intermediaries allow 2 equivalents to 12-point blank lines between “Notes Section” box and “Deductible Information.” Carriers allow one 12-point blank line between the “Notes Section” box and the “Deductible Information” section.

"Deductible Information” Section

- Print “Deductible Information:” title equivalent to 14-point bold mixed case type.
- Allow equivalent to 12-point blank line.
- Indent 3 bytes and print deductible messages equivalent to 12-point mixed case type.
- Suppress the “Deductible Information” section if there is no record of entitlement for the beneficiary, or denial.
- Suppress the Deductible Information section if all claims displayed on the MSN are denied for HMO involvement or transferred to another agency or carrier (e.g., Travelers, UMWA, carrier jurisdiction.)
- Print the appropriate deductible message(s) from the “Deductible/Coinsurance” section of §50.37.
- Multiple deductible messages should appear for outpatient MSN’s if multiple calendar years of service are displayed on the MSN and for inpatient MSN’s if multiple benefit periods appear. Print messages in chronological order by year. Allow one 12-point blank line between messages.

- Do not split the “Deductible Information” section. There will, in most cases, be only 1 message printed here. If the contractor cannot print the title and all deductible messages on 1 page, print all information on the next page.

- If there is more than 1 message, allow equivalent to 12-point blank line between each.

- Allow 2 equivalents to 12-point blank lines between the last line of the “Deductible Information” section and the “General Information” title.

- Suppress the “Deductible Information” section if all claims displayed on the MSN are denied for HMO involvement or transferred to another agency or carrier (e.g., Travelers, UMWA, carrier jurisdiction).

"General Information” Section

- Print “General Information” title equivalent to 14-point bold mixed case type.

- Allow equivalent to 12-point blank line.

- Indent 3 bytes from the margin and print “General Information” messages equivalent to 12-point mixed case type.

- Suppress the “General Information” section if there are no messages to print.

- Do not print the “General Information” title without at least 1 complete message following it on the same page.

- Do not split messages. Each message must be printed in its entirety on the same page.

- Allow equivalent to 12-point blank line between messages.

- Print the title “General Information (continued):” equivalent to 14-point bold mixed case type in the upper left corner of the next page below the header when information continues to another page.

- Messages for “General Information” should be clear, concise and relevant. Submit proposed messages to the Regional Office for approval. The RO will notify the CO of the need for the message and seek approval. The RO will determine the appropriate length of time to display each message.

- Allow 2 equivalents to 12-point blank lines between the last line of “General Information” and the “Appeals Information” title.

- If multiple messages are printed in this section, allow one 12-point blank line between messages. If no "General Information" messages are printed on the MSN, suppress the "General Information" section.

10.3.8 - Appeals Section

(Rev. 1, 10-01-03)

A3-3726.8, B3-7006.4, PM-AB-02-106

A - General Information About the Appeals Section

This section informs the beneficiary of his/her appeal rights. Print only Part B medical insurance language if only Part B information is on the MSN. Print only Part A information if only Part A information is on the MSN. Print both Part A and B appeals language side by side if both claim types are on the MSN.

B - Technical Specification

The following outlines the technical specifications for the Appeals section.

- The "Appeals Section" must be printed in its entirety. Display it at the bottom of the last page of the MSN if space permits. Otherwise, print it in its entirety at the top of the next page (which then becomes the last page).

- Print "Appeals Information - Part B" or "Part A," whichever is applicable, equivalent to 14-point bold mixed case type flush left. The word "(Outpatient)" or "(Inpatient)" should follow Part B or Part A.

- Allow equivalent to 12-point blank line.

- Print, "If you disagree with any claims decision on this notice, you can request an appeal by (appeal date). Follow the directions below:" in equivalent to 12-point mixed case type, flush left.

    - "If you disagree with any claims decision on this notice," and the appeal date should be bold.

    - The appeal date is 120 days from the notice date on page 1 for Part B and 120 days from the notice date on page 1 for Part A. Date format is month, day, year (e.g., October 1, 1997).

      NOTE: Section 1869(a)(3)(C) of the Act eliminates the distinction between the time limits for requesting a Part A reconsideration and Part B review by creating a 120-day time limit for filing requests for appeal of all initial determinations.

- Allow equivalent to 12-point blank line.

- Format each of the following 3 lines by indenting 11 bytes:
    - Intermediaries number 1 through 3 each and skip 3 additional bytes;
    - Carriers print the number followed by the closed parenthesis and skip 2 additional bytes;
    - Allow equivalent to 12-point blank line between each printed line. Print all information equivalent to 12-point mixed case type. This information should only be shown once and centered if both Part A and B appeals language is shown. (See exhibit 1 in §30.)

      "1. Circle the item(s) you disagree with and explain why you disagree.

      "2. Send this notice, or a copy, to the address in the "Customer Service Information" box on page 1. (You may also send any additional information you may have about your appeal.)

      "3. Sign here _____ Phone number (____) _____."

10.3.9 - Continuation Page

(Rev. 1, 10-01-03)

A3-3726.9, B3-7006.5

A - General Information about the Continuation Page

For MSNs that cannot be printed on 1 page, use a continuation page heading for the second and subsequent pages of the MSN. The heading contains the following:

- 1/2-inch margin;
- Beneficiary Medicare Number;
- "Page _____ of _____";
- Date of notice;
- Equivalent to 12-point blank line; and
- Remainder of MSN.

B - Technical Specifications for a Continuation Page

Use the following specifications to produce headings for subsequent pages of the MSN.

- Print "Your Medicare Number: _____" flush left equivalent to 12-point bold mixed case type.
- Print "Page _____ of _____" flush right equivalent to 10-point mixed case type on the same line as "Your Medicare Number."
- Print date of notice flush right equivalent to 10-point type directly under "Page _____ of _____." Date format is month, day, year, (e.g., October 1, 1997).
- (CARRIERS ONLY): Allow two 12-point blank lines between the heading for the continuation page and remaining portion of the MSN.

10.3.10 - MSN Calculations

(Rev. 1, 10-01-03)

This section provides calculations for correctly displaying dollar amounts in certain columns of the MSN. The examples of the MSN statements are for **illustration purposes only**. For exact reproduction of the MSN statement, refer to the exhibits in §30.

10.3.10.1 - Intermediary Calculations

(Rev. 1, 10-01-03)

A3-3726.10

A - "You May Be Billed" Column

The following chart is to be used to display the "You May Be Billed" amounts for each service line on outpatient claims other than those that have a Medicare secondary payment less than the amount Medicare would have paid if it were primary. See the Medicare Secondary Payer Manual, Chapter 5, if the Medicare secondary payment is less than the amount Medicare would pay if it were primary.

Calculations for Completing "You May Be Billed" Column - Outpatient Claims	**Instructions/Source of Dollar Amount for Calculations**
A. Service line billed amount	This is the service line billed amount. This amount should be shown in the "Amount Charged" column of the MSN.

Calculations for Completing "You May Be Billed" Column - Outpatient Claims	**Instructions/Source of Dollar Amount for Calculations**
B. Psychiatric reduction	B = A x .375 This is applicable only to services subject to the outpatient psychiatric limitation. For all other services, B = 0.
C. Amount remaining after psychiatric reduction	C = A - B.
D. Deductible applied	This is the amount of deductible applied on the service line. If no deductible applied, D = 0.
E. Amount charged less deductible	E = C - D.
F. Less Medicare copayment amount	Depending upon the service, F may equal any of: 1. E - where services are paid at 100% of the approved amount; 2. 80% of E - where coinsurance is based on approved amount; 3. E minus 20% of E - where coinsurance is based on charges; or 4. OPPs payment amount minus the fixed beneficiary copayment where hospital outpatient PPS is involved.
G. Amount after deductible, copayment and psychiatric reduction	G = E - F.
H. Of the billed amount	This is dollar amount shown in "A."
I. Less what Medicare owes	This is the dollar amount shown in "G."
J. Net responsibility	J = H - I.
K. Plus charges that Medicare does not cover	This step represents charges that Medicare does not cover shown in the "Noncovered Charges" column on the MSN. Charges for which the beneficiary is determined to have no liability should be excluded from this step. Exclude dollar amounts for denials

Calculations for Completing "You May Be Billed" Column - Outpatient Claims	Instructions/Source of Dollar Amount for Calculations
	such as: • Services determined not to be medically necessary and the beneficiary was not informed in writing, in advance, that the services may not be paid; • The provider failed to tell the beneficiary if the diagnostic test was purchased, from whom it was purchased, the acquisition cost of the purchased test, or the cost of the professional component; • Missing information such as ICD-9, UPIN, etc.; • The charge was denied as a duplicate; • The service was part of a major surgery, test panel or bundled code; or • The service was denied/reduced because of utilization reasons.
L. Beneficiary responsibility	L = J + K Display this amount in the "You May Be Billed" column for service lines on outpatient claims. Claims submitted with a beneficiary paid amount require the additional calculations shown in Subsection C below.

B - Display of the "You May Be Billed" Column for MSP Claims:

If the Medicare secondary payment plus the amount the primary insured paid equals or exceeds what Medicare would have paid, the "You May Be Billed" column for each approved service should display "$0.00."

If the primary insurer paid amount is less than what Medicare would have paid, the amount shown in "You May Be Billed" column for each service line needs to be reduced using the following formula.

> For the first service line, the amount "You May Be Billed" = Deductible + Coinsurance - Primary Paid Amount + Noncovered Charges.
>
> For the second service line, the same formula would be followed with the Primary Amount equaling the Primary Paid minus the Deductible + Coinsurance from the first line.

Continue in this manner until the primary paid amount equals either $0.00 or the Deductible + Coinsurance equals $0.00.

EXAMPLE 1:

On this claim, the Medicare payment would have been $2,172.54. The primary insurer paid $2,400.00, and $543.14 would have been applied to coinsurance.

Services Provided	Amount Charged	Non-Covered Charges	Deductible and Coinsurance	You May Be Billed	See Notes Section
Sick Hospital **123 West Street** **Little Rock, AR 72204** Referred by: John Smith, M.D.					
01/01/95 - 01/31/95 Dialysis	$2,715.68	$00.00	$543.03	$00.00	a

Notes Section:
a. Your primary group's payment satisfied Medicare deductible and coinsurance.

EXAMPLE 2:

On this claim, the Medicare payment would have been $230.56. These services have no coinsurance applied, and $100 was applied to deductible. The primary insurer paid $800.00.

Services Provided	Amount Charged	Non-Covered Charges	Deductible and Coinsurance	You May Be Billed	See Notes Section
Sick Hospital **456 Sick Lane** **Wellness, TX 75256** Referred by: John Apple, M.D.					
Clinical Chemistry Test	$300.00	$00.00	$00.00	$00.00	
Radiologic Exam	600.00	00.00	100.00	00.00.	
Claim Total	**$900.00**	**$00.00**	**$100.00**	**$00.00**	

Notes Section:

a. Your primary group's payment satisfied Medicare deductible and coinsurance.

EXAMPLE 3:

On this claim, the Medicare payment would have been $380.35. The primary insurer paid $350.00, $100 was applied to deductible and $205.00 to coinsurance. (Since it is not clear from the paid amount whether the take home drugs were paid, the MSN must show as "You May Be Billed.")

Services Provided	Amount Charged	Non-Covered Charges	Deductible and Coinsurance	You May Be Billed	See Notes Section
Well Hospital **123 Well Lane** **Secondary, Texas 75123** Referred by: John Sick, M.D.					
Pharmacy	$80.00	$00.00	$80.00	$00.00	
Take Home Drugs	20.00	20.00	00.00	20.00	a
Prosthetics/Orthotic (L3800)	150.00	00.00	46.00	00.00	
Medical/Surgical Supplies	50.00	00.00	10.00	00.00	
Culture (87117)	30.00	00.00	00.00	00.00	b
X-Ray (71020)	45.00	00.00	9.00	00.00	
Bronchoscopy (31622)	500.00	00.00	100.00	00.00	
Anesthesia	200.00	00.00	40.00	00.00	
Immunization (90732)	20.00	00.00	00.00	00.00	b
EKG (93005)	100.00	00.00	20.00	00.00	
Vaccine Administration (G0009)	15.00	00.00	00.00	00.00	b
Claim Total	**$1,210.00**	**$20.00**	**$305.00**	**$20.00**	**c**

Notes Section:

a. Medicare does not pay for this item or service.

b. This service is paid at 100% of Medicare approved amount.

c. Your primary group's payment satisfied Medicare deductible and coinsurance.

C - Display of the "You May Be Billed" Column for Claims Submitted with a Beneficiary Paid Amount

If a claim is submitted with a beneficiary paid amount, the amount(s) in the "You May Be Billed" column will be reduced by the amount the beneficiary prepaid the provider.

Apply the beneficiary paid amount to each service line sequentially until the beneficiary paid amount is reduced to zero or all service lines have been considered.

Step 1: If the amount the beneficiary paid is less than or equal to the amount shown for the "You May Be Billed" column, subtract the amount the beneficiary paid from that amount, and display the difference in the "You May Be Billed" column for that service line.

Step 2: If the amount the beneficiary paid is greater than the amount calculated for the "You May Be Billed" column, subtract the "You May Be Billed" amount for the first service line from the amount the beneficiary paid, and show zero in the "You May Be Billed" column.

Repeat these steps with any remaining beneficiary paid amounts. If a balance remains after all services lines have been considered, that amount should match the check amount to the beneficiary on that claim. If payment was made to the beneficiary, the balance should be shown in the appropriate blank of message 34.4. If a check was not issued, print message 34.2.

EXAMPLE 4:

On this claim, the beneficiary paid $75.00.

Services Provided	Amount Charged	Non-Covered Charges	Deductible and Coinsurance	You May Be Billed	See Notes Section
Sick Hospital **123 West St.** **Jacksonville, FL 32231** Referred by: John Smith, M.D.					
Dialysis	$367.68	$00.00	$73.53	$00.00	a

Notes:
a. We are paying you $1.47 because the amount you paid the provider was more than you may be billed.

10.3.10.2 - Carrier Calculations

(Rev. 1, 10-01-03)

B3-7007.1-7007.9

A. "Medicare Paid You/Provider" Column - Assigned and Unassigned Claims

The following chart is to be used to display the Medicare paid amount for each service line on assigned and unassigned claims other than those that have a Medicare secondary payment less than the amount Medicare would have paid if it were primary.

Steps for Displaying "Medicare Paid Amounts" on the Service Line	**Instructions/Source of Dollar Amounts**
A. Service line approved amount	This is the approved amount for the service. Do not include interest amounts paid or applied to the service line.

Steps for Displaying "Medicare Paid Amounts" on the Service Line	Instructions/Source of Dollar Amounts
B. Mental Health Treatment Limitation	B = A x 37.5 This is applicable only for services subject to the outpatient mental health treatment limitation. For all other services, B = 0.
C. Amount remaining after mental health treatment limitation	C = A - B.
D. Deductible applied	This is the amount of deductible applied on the service line. If no deductible applied, D = 0.
E. Approved amount less deductible	E = C - D.
F. Less Medicare copayment	F = E x .20 Services paid at 100% of the approved amount do not have a copayment. For services paid at 100%, F = 0.
G. Amount after deductible, copayment and mental health treatment limitation	G = E - F.
H. Less 10% for late filing	H = G x .10 If service line is part of an unassigned claim or there is no reduction for late filing, H = 0.
I. Payment after reduction	I = G - H.
J. Less Balanced Budget Law Reduction	The total Balanced Budget Law reductions applied to the service line. If no reduction, J = 0.
K. Payment after reduction	K = I - J.
L. Medicare paid amount	L = K - Display this amount in the "Medicare Paid You/Provider" column.

B. "You May Be Billed" Column - Assigned Claims

The following chart is to be used to display the "You May Be Billed" amounts for each service line on assigned claims other than those that have a Medicare secondary payment less than the amount Medicare would have paid if it were primary.

Calculations for Completing "You May Be Billed" Column - Assigned Claims	**Instructions/Source of Dollar Amount for Calculations**
A. Service line approved amount	This is the service line approved amount. This amount should be shown in the "Medicare Approved" column of the MSN.
B. Mental Health Treatment Limitation	B = A x 37.5 This is applicable only to services subject to the outpatient psychiatric limitation. For all other services, B = 0.
C. Amount remaining after mental health treatment limitation	C = A - B.
D. Deductible applied	This is the amount of deductible applied on the service line. If no deductible applied, D = 0.
E. Approved amount less deductible	E = C - D.
F. Less Medicare copayment amount	F = E x .20 Services paid at 100% of the approved amount do not have a copayment. For services paid at 100%, F = 0.
G. Amount after deductible, copayment and mental health treatment limitation	G = E - F.
H. Of the approved amount	This is dollar amount shown in "A."
I. Less what Medicare owes	This is the dollar amount shown in "G."
J. Net responsibility	J = H - I.

Calculations for Completing "You May Be Billed" Column - Assigned Claims	Instructions/Source of Dollar Amount for Calculations
K. Plus charges that Medicare does not cover	This step represents charges that Medicare does not cover and the beneficiary is liable. Charges for which the beneficiary is determined to have no liability should be excluded from this step. Exclude dollar amounts for denials or reductions such as: • Services determined not to be medically necessary and the beneficiary was not informed in writing, in advance, that the services may not be paid; • The provider failed to tell the beneficiary if the diagnostic test was purchased, from whom it was purchased, the acquisition cost of the purchased test, or the cost of the professional component; • Missing information such as ICD-9, UPIN, etc.; • The charge was denied as a duplicate; • The service was part of a major surgery, test panel or bundled code; or • The service was denied/reduced because of utilization reasons.
L. Beneficiary responsibility	L = J + K Display this amount in the "You May Be Billed" column for service lines on assigned claims. Claims submitted with a beneficiary paid amount require additional calculations. See Subsection F below.

C. "You May Be Billed" Column - Unassigned Claims

The following chart is used to display the "You May Be Billed" amounts for each service line on unassigned claims other than those that have a Medicare secondary payment less than the amount Medicare would have paid if it were primary.

Calculations for Completing "You May Be Billed" Column - Unassigned Claims	**Instructions/Source of Dollar Amount for Calculations**
A. Of the total charges	The billed amount for the service line.
B. Approved amount	The service line approved amount.
C. Amount exceeding limiting charge	For unassigned services subject to the limiting charge, this is the actual dollar amount by which the limiting charge is exceeded. If the amount is less than $1.00, C = 0. Do not include services being reduced or denied for any of the conditions under E.
D. Net Responsibility	D = A - C.
E. Less charges beneficiary is not liable for	This step represents charges that were denied or reduced and the beneficiary is not liable for the denial or the reduction. Include dollar amounts for denials or reductions such as: • Services determined not to be medically necessary, and the beneficiary was not informed in writing in advance that the services may not be paid; • The provider failed to tell the beneficiary if the diagnostic test was purchased, from whom it was purchased, the acquisition cost of the purchased test, or the cost of the professional component; • The claim did not have an ICD-9 code listed, or the service was not linked to an ICD-9 code; • The charge was denied as a duplicate; • The service was part of a major surgery, test panel, or bundled code; • The service was denied because of utilization reasons; or • Rebundling of services when the minor

	service was paid before the major service was billed. Use the amount allowed for the minor service in step E, or Reductions due to coverage.
F. Beneficiary Responsibility	F = D - E Display this amount in the "You May Be Billed" column for unassigned claims. Claims submitted with a beneficiary paid require additional calculations, therefore, proceed to §10.3.10.2(f).

D. Display of the "Medicare Paid You" and "Medicare Paid Provider" Columns for MSP Claims

Medicare secondary payment is computed by the MSP pay module based on claim totals.

However, the MSN displays calculations by service line. In order to complete the "Medicare Paid Provider" and "Medicare Paid You" columns for MSP claims, the contractor must apportion the total amount Medicare paid on the claim among the approved service lines.

For the first approved service line, show the lesser of 80 percent (50 percent if the outpatient psychiatric limit applies, or 100 percent for services paid at 100 percent) of the Medicare approved amount, less any deductible applied, or the amount Medicare actually paid on the claim.

For the second approved service line, show the lesser of:

- 80 percent (50 percent if the outpatient psychiatric limit applies, or 100 percent for services paid at 100 percent) of the Medicare approved amount less any deductible applied, or

- The actual amount Medicare paid on the claim minus the amount shown under Medicare Paid for the prior approved service lines.

Continue on following lines in this manner until the entire Medicare secondary payment for the claim has been exhausted.

EXAMPLE:

Dates of Service	Services Provided	Amount Charged	Medicare Approved	Medicare Paid Provider	You May Be Billed	See Notes Section
John Smith, M.D. **123 West Street** **Jacksonville, FL 32231**						
06/06/95	1 Office/Outpatient Visit, Est. (99214)	$80.00	$57.25	$45.80	$0.00	b
06/06/95	1 Removal of Skin Lesion (11441)	$65.00	$49.71	$14.20	$0.00	b, c
06/06/95	1 Destroy Benign/Premal. Lesion (17000)	$40.00	$16.52	$0.00	$0.00	b, c
Claim Total		**$185.60**	**$123.48**	**$60.00**	**$0.00**	**a**

Notes Section:

a. Medicare's secondary payment is $60.00. This is the difference between the primary insurer's approved amount of $150.00 and the primary insurer's paid amount of $90.00.

b. The amount listed in the "You May Be Billed" column assumes that your primary insurer paid the provider. If your primary insurer paid you, then you are responsible to pay the provider the amount your primary insurer paid to you plus the amount in the "You May Be Billed" column.

c. Medicare benefits are reduced because some of these expenses have been paid by your primary insurer.

E. Display of the "You May Be Billed" Column for MSP Claims

1. Assigned Claims

If the Medicare secondary payment plus the amount the primary insurer paid equals or exceeds the Medicare approved amount, display "$0.00" in the "You May Be Billed" column for each approved service line.

If the Medicare secondary payment plus the amount the primary insurer paid is less than the Medicare approved amount, carriers calculate the total beneficiary responsibility for approved services by subtracting the sum of the primary insurer's payment and the Medicare secondary payment from the total Medicare approved amount for those services.

> Amount Medicare Approved on Claim - (Primary Insurer Payment + Medicare Payment) = Total Beneficiary Responsibility

For the first approved service line, carriers show the lesser of 20 percent (50 percent if the outpatient psychiatric limit applies) of the Medicare approved amount or the beneficiary's total responsibility for all approved services on the claim.

For the second approved service line, carriers show the lesser of 20 percent (50 percent if the outpatient psychiatric limit applies) of the approved amount for the line or the beneficiary's total responsibility for approved services minus the amount shown for the prior approved service line.

Continue in this manner until the entire beneficiary responsibility has been exhausted.

Enter $0.00 in the "You May Be Billed" column for denied services for which the beneficiary is not liable.

Enter the amount charged in the "You May Be Billed" column for denied services for which the beneficiary is responsible.

NOTE: If there is an "obligated to accept" amount submitted on the claim, and that amount is greater than zero but less than the Medicare approved amount, use the "obligated to accept" amount in place of the Medicare approved amount when performing the above calculations.

EXAMPLE:

On this claim, the regular Medicare payment was the lowest of the calculated secondary payments. $38.31 was applied to the annual deductible. The primary insurer allowed $134.19 and paid $52.38.

Dates of Service	Services Provided	Amount Charged	Medicare Approved	Medicare Paid Provider	You May Be Billed	See Notes Section
John Smith, M.D. **123 West Street** **Jacksonville, FL 32231**						
06/06/95	1 Evaluation of Wheezing (94060)	$55.82	$55.82	$14.01	$5.10	b, c
06/06/95	1 Respiratory Flow Volume (94375)	$36.43	$36.43	$29.14	$0.00	c
06/06/95	1 Lung Function Test (94200)	$17.42	$17.42	$13.94	$0.00	c
06/06/95	1 Measure Blood Oxygen (94761)	$24.52	$24.52	$19.62	$0.00	c
Claim Total		**$134.19**	**$134.19**	**$76.71**	**$5.10**	**a**

Notes Section:

a. Your provider is allowed to collect a total of $134.19 on this claim. Your primary insurer paid $52.38 and Medicare paid $76.71. You are responsible for the unpaid portion of $5.10.

b. $38.31 of this approved amount has been applied to your deductible.

c. The amount listed in the "You May Be Billed" column assumes that your primary insurer paid the provider. If your primary insurer paid you, then you are responsible to pay the provider the amount your primary insurer paid to you plus the amount in the "You May Be Billed" column.

2. Unassigned Claims

The amount in the "You May Be Billed" column for approved services is the amount charged or the limiting charge, whichever is less.

NOTE: If there is an "obligated to accept" amount submitted on the claim and that amount is greater than zero but less than the amount charged or the limiting charge, use the "obligated to accept" amount when performing this calculation.

Enter $0.00 in the "You May Be Billed" column for denied services for which the beneficiary is not liable. Enter the amount charged in the "You May Be Billed" column for denied services for which the beneficiary is responsible.

F. Display of the "You May Be Billed" Column for Claims Submitted with a Beneficiary Paid Amount

1. Assigned Claims

If an assigned claim is submitted with a beneficiary paid amount, the amount(s) in the "You May Be Billed" column will be reduced by the amount the beneficiary prepaid the provider.

Apply the beneficiary paid amount as indicated below to each service line sequentially until the beneficiary paid amount is reduced to zero or all service lines have been considered.

Step 1: Subtract the amount of the beneficiary check, if any, from the patient amount submitted on the claim. Use the difference as the new patient paid amount. If there was no check to the beneficiary, use the patient paid amount submitted on the claim for remaining steps.

Step 2: If the new patient paid amount is less than or equal to the amount calculated for the "You May Be Billed" column, subtract the new patient paid amount from the original "You May Be Billed" amount, and display the difference in the "You May Be Billed" column for that service line.

Step 3: If the new patient paid amount is greater than the amount calculated for the "You May Be Billed" column, subtract the original "You May Be Billed" amount for the first service line from the new patient paid amount, and show zero in the "You May Be Billed" column.

Repeat these steps with any remaining beneficiary paid amounts.

2. Unassigned Claims

If an unassigned claim is submitted with a beneficiary paid amount, the amount(s) in the "You May Be Billed" column will be reduced by the amount the beneficiary prepaid the provider. Apply the beneficiary paid amount for each service line sequentially until the beneficiary paid amount is reduced to zero or all service lines have been considered.

Step 1: If the amount the beneficiary paid is less than or equal to the amount calculated for the "You May Be Billed" column, subtract the amount the beneficiary paid from that

amount, and display the difference in the “You May Be Billed” column for that service line.

Step 2: If the amount the beneficiary paid amount is less than or equal to the amount calculated for the “You May Be Billed” column, subtract the “You May Be Billed” amount for the first service line from the amount the beneficiary paid, and show zero in the “You May Be Billed” column for that service line.

Repeat these steps with any remaining beneficiary paid amounts.

If there is a balance after all service lines have been considered on unassigned claims, that amount is what the beneficiary overpaid the provider. Carriers have the option of printing claim level message 34.3 in this situation if their system permits.

Print message 34.2 on assigned claims when the beneficiary paid amount does not exceed coinsurance and deductible and for all unassigned claims submitted with a beneficiary paid amount.

EXAMPLE 1: Assigned claim - beneficiary paid amount equals $35.00

Show the "You May Be Billed" amounts after calculations in §10.3.10.2 but prior to reduction for beneficiary paid amount (steps 1, 2 and 3 above). See Example 2 for results after step 1, 2, and 3 have been applied.

Dates of Service	Services Provided	Amount Charged	Medicare Approved	Medicare Paid Provider	You May Be Billed	See Notes Section
John Smith, M.D. **123 West Street** **Jacksonville, FL 32231**						
06/06/97	1 Eye Refraction (92015)	$22.00	$0.00	$0.00	$22.00	b
06/06/97	1 Eye Exam & Treatment (92014)	$51.16	$51.16	$40.93	$10.23	
06/06/97	1 Visual Field Exam (92081)	$21.54	$21.54	$17.23	$4.31	
Claim Total		**$94.70**	**$72.70**	**$58.16**	**$36.54**	**a**

Notes Section:

a. Of the total $58.16 paid on this claim, Medicare is paying you $20.46 because you paid your provider more than your 20 percent coinsurance on Medicare approved services. The remaining $37.70 was paid to the provider.

b. Eye refractions are not covered.

EXAMPLE 2: Assigned claim - beneficiary paid amount equals $35.00

This example shows example 1 after steps 1, 2, and 3 have been applied.

Dates of Service	Services Provided	Amount Charged	Medicare Approved	Medicare Paid Provider	You May Be Billed	See Notes Section
John Smith, M.D. **123 West Street** **Jacksonville, FL 32231**						
06/06/97	1 Eye Refraction (92015)	$22.00	$0.00	$0.00	$7.46	b.
06/06/97	1 Eye Exam & Treatment (92014)	$51.16	$51.16	$40.93	$10.23	
06/06/97	1 Visual Field Exam (92081)	$21.54	$21.54	$17.23	$4.31	
Claim Total		**$94.70**	**$72.70**	**$58.16**	**$22.00**	**a**

Notes Section:

a. Of the total $58.16 paid on this claim, Medicare is paying you $20.46 because you paid your provider more than your 20 percent coinsurance on Medicare approved services. The remaining $37.70 was paid to the provider.

b. Eye refractions are not covered.

Explanation of Example 2

The beneficiary check amount of $20.46 is subtracted from the $35.00 patient paid amount submitted on the claim leaving a difference of $14.54. The new patient-paid amount is $14.54.

The $14.54 is subtracted from the $22.00 beneficiary liability from service line 1. The difference is displayed in the “You May Be Billed” column for service line 1.

G. Display of the “Medicare Paid You” Column for Unassigned Claims with a Previous Overpayment Amount Withheld

The “Medicare Paid You” column should show the actual amount that would have been paid if no previous overpayment had been withheld from the check issued to the

beneficiary. Use message 32.1 to show the amount by which the check is reduced to recover an overpayment from the beneficiary.

H. Display of the "Medicare Paid You" Column for Assigned and Unassigned Adjustment Claims

Show all service lines for the adjustment claim. The "Medicare Approved" and "Medicare Paid" columns will display the same allowed and paid amounts as were shown on the original MSN for service lines that are not subject to adjustment.

The "Medicare Approved" and "Medicare Paid" columns for adjusted service lines will show the total combined amount approved and paid for both the original and adjusted claim. Likewise, "Claim Total" lines for adjusted claims will reflect the combined total amounts approved and paid for the original and adjusted claim.

The "You May Be Billed" column will show the beneficiary's total responsibility. The contractor uses message 31.13 on all adjustments where a partial payment was previously made.

10.3.11 - Back of the MSN - Carriers and Intermediaries

(Rev. 1, 10-01-03)

A3-3726.11, B3-7008, A-01-93, A-00-58

A - General Information about the Back of the MSN:

Print the appropriate information on the back of each page of the MSN. The information may be preprinted.

Print the back of the MSN at no more than 6 lines to an inch.

B - Technical Specifications for the Back of the MSN:

Contractors include the following information in this order:

- Title

Intermediaries: "IMPORTANT INFORMATION YOU SHOULD KNOW ABOUT YOUR MEDICARE BENEFITS," centered as shown in exhibits in §30 and printed equivalent to 14-point bold uppercase type in a band of 10-percent shading for MSNs showing both outpatient and inpatient information. (See exhibit 2, "Back of Notice Outpatient and Inpatient Combined.")

Carriers: "Important Information You Should Know About Your Medicare Part B Benefits," centered and printed in 18 point italic type in a band of 10% shading.

- Allow equivalent to 12-point blank line.

- Subtitle/Statement.

Intermediaries: "For more information about services covered by Medicare, please see your Medicare Handbook." This subtitle is centered and printed equivalent 14-point mixed case type.

Carriers: "This part of the notice answers some questions about receiving Medicare payments. If you have other questions, see your copy of the Medicare Handbook or call us for more information." printed in 12 point bold type, italics as shown in exhibits in §30.

- Print horizontal line (0.048" wide extending from left to right margin).

- Allow equivalent to 12-point blank line.

Intermediaries:

Print the following information single-spaced in two newspaper style columns equivalent to 11-point mixed case type. Print the headings equivalent to 11-point bold uppercase type.

- Print a line down the center of the page dividing the two columns as shown in exhibit 2, "Back of Notice Outpatient and Inpatient Combined."

- In the following paragraphs of exhibit 2, print the indicated words equivalent to 11-point bold type:

    - Paragraph 2 - "The Amount You May Be Billed"; "Part A"; "an inpatient hospital deductible"; "a coinsurance amount for the 61st through 90th days"; "a coinsurance amount for each Lifetime Reserve Day"; "a blood deductible"; "an inpatient coinsurance for the 21st through the 100th days." "skilled nursing facility"; "not covered".

    - Paragraph 4 - "annual deductible"; "Part B"; "coinsurance"; "not covered".

    - Paragraph 6 - "Part A"; "60 days"; "Part B", "6 months"; "help with your appeal".

- Allow blank line.

- Print horizontal line (0.048" wide extending from left to right margin).

- Print "Centers for Medicare & Medicaid Services" equivalent to 10-point bold italic type in a band of 10-percent shading.

Intermediaries must change the back of the MSN using the following language to reflect Outpatient Prospective Payment System (OPPS) changes in coinsurance.

"THE AMOUNT YOU MAY BE BILLED for **Part B** services includes:

- **"An annual deductible**, the first $100 of Medicare Part B charges each year;
- "After the deductible has been met for the year, depending on services received, a **coinsurance** amount (20 percent of the amount charged), or a fixed copayment for each service; and
- "Charges for services or supplies that are **not covered** by Medicare. You may not have to pay for certain denied services. If so, a note on the front will tell you."

Also, print the following message in the "General Information" Section:

> "If the coinsurance amount you paid is more than the amount shown on your notice, you are entitled to a refund. Please contact your provider."

Carriers:

Print the following questions and answers single spaced in two newspaper-style columns. Print the numbers and questions in 10 point bold type. Use bold and italics under #2, #3, and #4 as shown in exhibits in §30.

1. **What should I do if I have questions about this notice?**
   If you have questions about this notice, call, write, or visit us and we will tell you the facts that we used to decide what and how much to pay. Turn to the front of this notice; our address and phone number are on the bottom of the page.

2. **Can I appeal how much Medicare paid for these services?**
   If you do not agree with what Medicare approved for these services, you may appeal our decision. To make sure that we are fair to you, we will not allow the same people who originally processed these services to conduct this review.

   However, in order to be eligible for a review, you must write to us within 6 months of the date of this notice, unless you have a good reason for being late (for example, if you had an extended illness which kept you from being able to file on time).

   Turn to the front of this notice; the deadline date and our address are on the bottom of the page. It may help your case if you include a note from your doctor or supplier (provider) that tells us what was done and why.

   If you want help with your appeal, or if you have questions about Medicare, you can have a friend or someone else help you. There are also

groups, such as legal aid services, who will provide free advisory services if you qualify. In addition, volunteers at Medicare peer counseling programs in your area can also provide you with assistance. If you would like more information on how to get in touch with a counselor, contact us at the address or phone numbers on the bottom of the front page of this notice.

3. **How much does Medicare pay?**
   The details on the front of this notice explain how much Medicare paid for these services. See your copy of The Medicare Handbook for more information about the benefits you are entitled to as a beneficiary in the Medicare Part B program. If you need another copy of the handbook, call or visit your local Social Security Office.

   Medicare may make adjustments to your payment. We may reduce the amount we pay for services by a certain percentage (Balanced Budget Law). If your provider accepted assignment, you are not liable to pay the amount of this reduction. We pay interest on some claims not paid within the required time.

   All Medicare payments are made on the condition that you will pay Medicare back if benefits are also paid under insurance that is primary to Medicare. Examples of other insurance are employer group health plans, automobile medical, liability, no fault or workers' compensation. Notify us immediately if you have filed or could file a claim with insurance that is primary to Medicare.

4. **How can I reduce my medical costs?**
   Many providers have agreed to be part of Medicare's participation program. That means that they will always accept the amount that Medicare approves as their full payment. Write or call us for the name of a participating provider or for a free list of participating providers.

   A provider who accepts assignment for covered services can charge you only for the part of the annual deductible you have not met and the copayment which is 20 percent of the approved amount.

   If you are treated by one of these doctors, you can save money. See The Medicare Handbook for more information about how you can reduce your medical costs.

   Generally a doctor who has not accepted assignment may not charge more than 115 percent of the Medicare approved amount for services provided in 1993 or later. This is known as the limiting charge. Contact us if assignment was not accepted, and you think your doctor charged more than the limiting charge.

Some states have laws that could further reduce your medical costs. Please see The Medicare Handbook published in 1993 or later for more information.

5. **How can I use this notice?**
   You can use this notice to:

   - Contact us immediately if you think Medicare paid for a service you did not receive;
   - Show your provider how much of your deductible you have met;
   - Claim benefits with another insurance company. If you send this notice to them, make a copy of it for your records.

Two blank lines.

Horizontal line (0.048" wide extending from left to right margin).

Blank line.

Print "Keep this notice for your records." in 12 point bold type.

Print "Centers for Medicare & Medicaid Services" in 12 point bold italic type.

10.3.12 - Separation of Claim Line Items on MSN

(Rev. 1, 10-01-03)

A3-3726.12, B3-7010

In the following situations, provide separate line items on the MSN:

- The same services were provided by the same provider, but the billed amounts are not all covered;
- The same services were provided by the same providers, but the denial or reduction reasons are not the same for each service;
- (CARRIERS ONLY): Different services were provided by the same physician/supplier; or
- (CARRIERS ONLY): The same services were provided by the same physician/supplier, but the billed amounts are not the same for each service.

10.3.13 - Suppression of Claims From MSNs

(Rev. 1, 10-01-03)

A3-3726.13, B3-7011

Carriers and intermediaries have the option to suppress claims from MSNs when **all** of the following three conditions apply:

- The claim is a coordination of benefits (crossover) claim for Medicaid;
- There is no resulting beneficiary liability; and
- Suppression of the MSN is cost effective.

In addition, if the contractor's system denies an exact duplicate of a claim, the contractor may suppress the claim from the MSN. An exact duplicate claim is one in which every field of the duplicate claim matches every field of the original claim.

Since appeal rights are not affected, do not display claims on MSNs for services paid at 100 percent of the fee schedule where no deductible or coinsurance is applied, e.g. diagnostic laboratory services. If other services on that claim will appear on the MSN, include all services being paid.

Upon the beneficiary's request, create and send MSNs for previously suppressed claims.

Do not suppress claims from MSNs when **any** of the following conditions apply:

- One or more services were denied because one of the exclusions from Medicare coverage in 1862(a)(1) of the Social Security Act (the Act) applies;
- The claim is denied as not filed within the time limits required by 1842(b)(3) of the Act;
- The claim is denied in full or in part because the beneficiary was not enrolled in Part A or B of Medicare when the services in question were provided; or
- An initial determination is made on a claim not later than the 45-day period beginning on the date the fiscal intermediary or the carrier receives a claim.

20 - Specifications for Spanish MSN

(Rev. 1, 10-01-03)

20.1 - General

(Rev. 1, 10-01-03)

B3-7006.6, AB-02-106

The Spanish MSN should be developed using the same specifications as for the English MSN. The actual text of the MSN will be in Spanish. Approved language translations for the Spanish MSN are as follows. Some modifications to page definitions, form definitions and print programs may be necessary to allow for the Spanish text.

20.2 - Disclaimer Section

(Rev. 1, 10-01-03)

ENGLISH - THIS IS NOT A BILL

SPANISH - ESTA NOTIFICACIÓN NO ES UNA FACTURA

ENGLISH - Keep this notice for your records.

SPANISH - Retenga esta notificación para sus archivos.

NOTE: The above disclaimer, which is on the bottom of the first page, will be broken into two lines on the Spanish MSN. See Spanish MSN exhibit.

20.3 - Title Section

(Rev. 1, 10-01-03)

B3-7006.7

ENGLISH - Page (__) of (__)

SPANISH - Página (__) de (__)

ENGLISH - Medicare Summary Notice

SPANISH - Resumen de Medicare

ENGLISH - Your Medicare Number:

SPANISH - Su Número de Medicare:

ENGLISH - CUSTOMER SERVICE INFORMATION

SPANISH - INFORMACIÓN DE SERVICIOS AL CLIENTE

ENGLISH - If you have questions, write or call:

SPANISH - Si usted tiene preguntas, escriba o llame a:

ENGLISH - Local:

SPANISH - Local:

ENGLISH - Toll-free:

SPANISH - Libre de cargos:

ENGLISH - TTY for Hearing Impaired:

SPANISH - TTY Impedimento Auditivo:

ENGLISH - BE INFORMED

SPANISH - INFÓRMESE

ENGLISH - This is a summary of claims processed from (_____) through (_____).

SPANISH - Este es un resumen de reclamaciones procesadas desde (_____) hasta (_____).

ENGLISH - This is a summary of claims processed on (_____).

SPANISH - Este es un resumen de reclamaciones procesadas el (_____).

20.4 - Claims Information Section

(Rev. 1, 10-01-03)

B3-7006.8

ENGLISH - PART B MEDICAL INSURANCE - ASSIGNED CLAIMS

SPANISH - PARTE B SEGURO MÉDICO - RECLAMACIONES ASIGNADAS

ENGLISH - PART B MEDICAL INSURANCE - UNASSIGNED CLAIMS

SPANISH - PARTE B SEGURO MÉDICO - RECLAMACIONES NO ASIGNADAS

ENGLISH - PART B MEDICAL INSURANCE - ASSIGNED CLAIMS (continued)

SPANISH - PARTE B SEGURO MÉDICO - RECLAMACIONES ASIGNADAS (continuación)

ENGLISH - PART B MEDICAL INSURANCE - UNASSIGNED CLAIMS (continued)

SPANISH - PARTE B SEGURO MÉDICO - RECLAMACIONES NO ASIGNADAS (continuación)

ENGLISH - Claim number

SPANISH - Número de Reclamación

ENGLISH - Dates of Service

SPANISH - Fechas de Servicio

ENGLISH - Services Provided

SPANISH - Servicios Proporcionados

ENGLISH - Amount Charged

SPANISH - Cargos

ENGLISH - Medicare Approved

SPANISH - Medicare Aprobó

ENGLISH - Medicare Paid Provider

SPANISH - Medicare Pagó su Proveedor

ENGLISH - Medicare Paid You

SPANISH - Medicare le Pagó a Usted

ENGLISH - You May Be Billed

SPANISH - Podría Ser Facturado

ENGLISH - See Notes Section

SPANISH - Vea las Notas

ENGLISH - Claim Total

SPANISH - Reclamación Total

ENGLISH - Referred by:

SPANISH - Referido por:

20.5 - Message Section

(Rev. 1, 10-01-03)

B3-7006.9

ENGLISH - Notes Section:

SPANISH - Sección de Notas:

ENGLISH - (continued)

SPANISH - (continuación)

ENGLISH - Notes Section (continued):

SPANISH - Sección de Notas (continuación):

ENGLISH - Deductible Information:

SPANISH - Información de Deducible:

ENGLISH - General Information:

SPANISH - Información General:

ENGLISH - General Information (continued):

SPANISH - Información General (continuación)

20.6 - Appeals Section

(Rev. 1, 10-01-03)

B3-7006.10, PM-AB-02-106

ENGLISH - Appeals Information - Part B

SPANISH - Información de Apelaciones - Parte B

ENGLISH - If you disagree with any claims decision on this notice, you can request an appeal by (_____). Follow the instructions below:

SPANISH - Si usted no está de acuerdo con cualquier decisión tomada en esta notificación, usted puede apelar en o antes (_____). Siga las instrucciones indicadas abajo:

ENGLISH - Circle the item(s) you disagree with and explain why you disagree.

SPANISH - Indique con un círculo los detalles con los que usted no está de acuerdo y explique la razón.

ENGLISH - Send this notice, or a copy, to the address in the Customer Service Information box on page 1. (You may also send any additional information you may have about your appeal.)

SPANISH - Envíe esta notificación o una copia a la dirección indicada en la sección Información de Servicios al Cliente en la página 1. (Usted también puede enviar cualquier información adicional que tenga sobre su apelación.)

ENGLISH - Sign here _____ Phone Number (____)_____

SPANISH - Firme aquí _____ Su número de teléfono (____) _____

20.7 - Text and Specifications for Spanish MSN Back

(Rev. 1, 10-01-03)

B3-7006.11, PM-A-99-48

The Spanish back should be printed using the same specifications as the English version with the exceptions noted in the sections below.

20.7.1 - Carrier Spanish MSN Back

(Rev. 1, 10-01-03)

The Spanish back should be printed using the same specifications as the English version but with the text below. Print the title of the Spanish back centered as shown in the exhibits in §30.2 and printed in 14-point bold uppercase type in a band of 10-percent shading.

- INFORMACIÓN IMPORTANTE
- SOBRE SUS BENEFICIOS DEL SEGURO MÉDICO DE MEDICARE PARTE B
- Allow blank line.

- Subtitle: Centered and printed in 14-point mixed case type within the 10-percent shading.

- Para más información sobre los servicios cubiertos por Medicare, favor de ver su Manual de Medicare.

- Horizontal line (0.048” wide extending from left to right margin).

Print the following text single-spaced in two newspaper style columns using 11-point mixed case type. Print the headings in 11-point bold uppercase type. Print a line down the center of the page dividing the two columns as shown in exhibit 31.

- In the following paragraphs print the indicated words in 11-point bold type.

    - Paragraph 2 - “asignadas,” “no asignadas”, “asignación”, “médicos participantes"

    - Paragraph 3 - “no asignadas"

    - Paragraph 4 - “usted puede ser facturado”, “deducible anual”, “$100”, “coaseguro”, “cargo límite”, “no están cubiertos"

    - Paragraph 6 - “120 días a partir de la fecha de este Resumen”, “ayuda con su apelación"

SEGURO MÉDICO DE MEDICARE PARTE B: La Parte B de Medicare ayuda a pagar por servicios médicos, exámenes diagnósticos, servicios de ambulancia, equipo médico duradero y otros servicios de salud. El seguro de hospital (Parte A) ayuda a pagar por los servicios de hospitalización a pacientes en un hospital, servicios en una instalación de enfermería especializada seguido por una estadía en el hospital, servicio de cuidado de la salud en el hogar y cuidado de hospicio. Usted recibirá otra notificación si recibió servicios no asignados, servicios de la Parte A o servicios en una facilidad para paciente ambulatorio.

ASIGNACION DE MEDICARE: Las reclamaciones por servicios médicos, Parte B, pueden ser asignadas o no asignadas. Proveedores que aceptan la asignación acuerdan aceptar la cantidad aprobada por Medicare como pago completo. Medicare paga su parte de la cantidad aprobada directamente al proveedor. Usted podría ser facturado por la cantidad no cubierta por el deducible anual y el coaseguro. Usted puede comunicarse con nosotros a la dirección o número de teléfono indicado la sección, “Información de Servicios al Cliente”, en la parte del frente de este Resumen para obtener una lista de médicos participantes , los cuales siempre aceptan la asignación. Usted puede ahorrar dinero escogiendo un médico participante.

Médicos que someten reclamaciones no asignadas no acuerdan aceptar la cantidad aprobada por Medicare como pago completo. Generalmente, Medicare le paga a usted 80% de la cantidad aprobada después de sustraer cualquier parte del deducible anual que usted no haya completado. Un médico que no acepta la asignación le puede cobrar hasta

115% de la cantidad aprobada por Medicare. Esto es conocido como el "Cargo Límite". Algunos estados tienen límites de pagos adicionales. La sección de NOTAS en la parte del frente de este notificación le dirá si su médico ha excedido el cargo límite y la cantidad correcta a pagar a su médico bajo la ley.

SU RESPONSABILIDAD: La cantidad que aparece en la columna "Podría Ser Facturado" es su responsabilidad monetaria por los servicios que aparecen en este notificación Su responsabilidad:

- Deducible anual: los primeros $100 de Medicare Parte B de cargos aprobados cada año;
- Coaseguro: 20% de la cantidad aprobada después de haber completado el deducible para ese añ;
- La cantidad facturada hasta el cargo límite, por reclamaciones no asignadas, y
- Cargos por servicios/suministros que no están cubiertos por Medicare. Es posible que usted no tenga que pagar por ciertos de servicios denegados. Si este es el caso, una NOTA en la parte del frente, le indicará.

Si usted tiene un seguro suplementario, éste le podría ayudar a pagar estos cargos. Si usted usa esta notificación para reclamar beneficios suplementarios de otra compañía de seguros, haga una copia y guárdela en sus archivos.

CUANDO OTRO SEGURO PAGA PRIMERO: Todos los pagos de Medicare son hechos bajo la condición de que usted devuelva el pago a Medicare en caso de que los beneficios puedan ser pagados por un asegurador primario a Medicare. Los tipos de seguro que deberían pagar antes de que Medicare pague son: planes de seguro de salud patronal, seguro de no culpabilidad, seguro médico de automobiles, seguro de responsabilidad y compensación para trabajadores.

Notifíquenos inmediatamente si usted ha sometido o podría someter una reclamación al seguro primario antes que a Medicare.

SU DERECHO A APELAR: Si usted no está de acuerdo con la cantidad que Medicare aprobó por estos servicios, puede apelar la decisión. Usted debe someter su apelación dentro de 120 días a partir de la fecha de esta notificación. Siga las instrucciones para apelaciones en la parte del frente en la última página de esta notificación. Si usted necesita ayuda con su apelación, puede pedirle a un amigo o cualquier persona que le ayude. También hay grupos, como servicios legales, los cuales le aconsejarán libre de cargos, si usted es elegible. Usted puede comunicarse con nosotros y le daremos los nombres y números de teléfono de los grupos en su área. Para comunicarse con nosotros, favor de ver la sección "Información de Servicios al Cliente", en la parte del frente de este Resumen.

AYUDE A DETENER EL FRAUDE A MEDICARE: Fraude es una falsa representación de una persona o negocio para obtener pagos de Medicare. Algunos ejemplos de fraude son:

- Ofertas de mercancía o dinero a cambio de su Número de Medicare;
- Ofertas telefónicas o de puerta en puerta de servicios o artículos médicos gratis; y
- Reclamaciones sometidas a Medicare por servicios o artículos que usted no recibió;
- Si usted sospecha que una persona o negocio está envuelto en fraude, debe llamar a Medicare al Departamento de Servicios al Cliente, al teléfono indicado en la parte del frente de este notificación.

CONSEJERIA Y ASISTENCIA DE SEGURO: Todos los estados ofrecen Programas de Consejeria y Asistencia de Seguro. Consejeros voluntarios pueden ayudarle libre de cargos con sus preguntas de Medicare, incluyendo inscripción, sus derechos, problemas de primas y seguros Medigap. Si usted desea más información, favor de llamarnos al número indicado en la sección de “Información de Servicio al Cliente”, en la parte del frente de este Resumen.

Allow blank line.

Horizontal line (0.048” wide extending from left to right).

Print Centers for Medicare & Medicaid Services in 10-point bold italic type on a band of 10-percent shading.

20.8 - Intermediary Spanish MSN Back

(Rev. 1, 10-01-03)

PMs A-99-48, A-01-93

The Spanish back should be printed using the same specifications as the English version. However, the font size is 10 points. Use the text provided in the Spanish MSN exhibit.

In the following paragraphs of exhibit 2 in §30, print the indicated words in bold type. Where capitalized in this section, print in all capital letters.

Paragraph 1 - SEGURO DE HOSPITAL PARTE A (PACIENTE INTERNO), La cantidad por la cual usted podria recibir una factura incluye:

- un deducible de paciente interno en un hospital;
- una cantidad de coaseguro por los días 61 hasta 90;

- una cantidad de coaseguro por cada Día de Reserva Vitalicia;
- un deducible de sangre;
- un coaseguro de paciente interno por los días 21 hasta 100, facilidad de enfermería especializada;
- no están cubiertos.

Paragraph 2 - SEGURO MÉDICO PARTE B (PACIENTE EXTERNO), La cantidad por la cual usted podría ser factura incluye:

- **Un deducible anual**, los primeros $100 de Medicare Parte B de cargos aprobados cada año,
- Depués de que haya cumplido con el deducible, dependiendo de los servicios recibidos, **un coaseguro** (20% de la cantidad cobrada), o un **copago fijo** por cada servcio,
- Cargos por servicios/suministros que no están cubiertos por Medicare. Es posible que usted no tenga que pagar por ciertos cargos se servicios denegados. De ser el caso, una NOTA en la parte del frente le indicará.

Paragraph 3 - CUANDO OTRO SEGURO PAGA PRIMERO

Paragraph 4 - SU DERECHO A APELAR: 120 días ayuda con su apelación

Paragraph 5 - AYUDE A DETERNER EL FRAUDE A MEDICARE:

Paragraph 6 - CONSEJERIA Y ASISTENCIA DE SEGURO:

Also, print the following message in the “General Information” Section:

> "If the coinsurance amount you paid is more than the amount shown on your notice, you are entitled to a refund. Please contact your provider.”

Spanish Version:

> "Si la cantidad de coaseguro que usted pagó es mayor que la cantidad que muestra su notificación, tiene derecho a un reembolso. Por favor comuníquese con su proveedor.”

30 - Exhibits

(Rev. 1, 10-01-03)

Exhibits are available only electronically. Click on the link below to view. Close the exhibit file to return here.

30.1 - Intermediary Exhibits

(Rev. 1, 10-01-03)

A3-3726.13

The following exhibits show the MSN format, the back of the notice and selected displays. They provide a reference point for use in generating the format of the MSN. The data displayed in the exhibits is for illustration purpose only. The dates, the deductible and the coinsurance have not been updated for 2002 or 2003.

The following exhibits are presented as separate files in PDF format. To return here from the PDF file, just close the PDF file.

Exhibit 1 - Inpatient/Outpatient Combined

Exhibit 2 - Back of Notice Outpatient and Inpatient Combined

Exhibit 3 - Outpatient Psychiatric Services

Exhibit 4 - Deductible Applied

Exhibit 5 - Noncovered Service (Beneficiary is liable.)

Exhibit 6 - Split Pay Claim, Patient Paid, 100 Percent Services

Exhibit 7 - MSP Situations

Exhibit 8 - MSP With Noncovered Charge

Exhibit 9 - MSP (Cost Avoided)

Exhibit 10 - MSP (Partial Recovery - Beneficiary Has Some Liability Remaining)

Exhibit 11 - MSP (Full Recovery - Beneficiary Has No Liability Remaining)

Exhibit 12 - Home Health

Exhibit 13 - Hospice

Exhibit 14 - Spanish Inpatient/Outpatient Combined

Exhibit 15 - Spanish Back of Notice

30.2 - Carrier Exhibits

(Rev. 1, 10-01-03)

B3-7012

The following exhibits show the MSN format, the back of the notice and selected displays. They provide a reference point for use in generating the format of the MSN. The data displayed in the exhibits is for illustration purpose only. The dates, the deductible and the coinsurance information have not been updated for 2002 or 2003.

These are separate files in PDF format. To return here from the PDF file, just close the PDF file.

Exhibit 1 - Limiting Charge/Interest to the Beneficiary

Exhibit 2 - Outpatient Psychiatric Services Paid at 50 Percent

Exhibit 3 - Multiple Years of Service

Exhibit 4 - Assigned/Unassigned DME Rental

Exhibit 5 - Assigned - 10-Percent Late Filing Reduction

Exhibit 6 - Payment to Beneficiary on an Assigned Claim

Exhibit 7 - Medicare Secondary Payment

Exhibit 8 - Medicare Secondary Payment with Beneficiary Liability

Exhibit 9 - Back of Notice

Exhibit 10 - Spanish

Exhibit 11 - Spanish Back of Notice

40 - Explanatory and Denial Messages

(Rev. 1, 10-01-03)

A3-3726.14, B3-7013

The purpose of the MSN messages is to concisely communicate essential information to the beneficiary regarding claim determinations or to serve as an educational tool.

Messages are grouped in categories for ease of reference only. Unless specific messages are specified in instructions by CMS, contractors should select and use the most appropriate message(s) for each situation to explain the action taken on a service, item, or

claim. Contractors are instructed to use the most appropriate message for each situation regardless of message category.

Use multiple messages as appropriate including ones grouped within different categories. Use the message(s) which best explains the situation(s) in the claim.

All denied or reduced services must have an explanation.

The BBA of 1997 requires the amount of Medicare payment for each service be included on all Part A Benefit notices, including the MSN and Notice of Utilization (NOU.) Contractors use message 16.53 on all intermediary generated notices with payments.

The contractor may combine "add-on" messages with existing messages to create a single message within its file.

Each message on the file is tied to an alphabetic code on the MSN. Print no more than three alphabetic codes per claim level and three alphabetic codes per service line.

Messages containing fill-in blanks may be left as blanks for filling in by the system or may be entered into the system with blanks pre-filled to create as many specific messages as there are fill-in situations.

The message numbering in this section does not have to be used in contractor message generating systems.

Certain messages are mandated. These messages and the situations for which they are mandated are identified in §70. This does not eliminate the need to use other messages required by instructions elsewhere in the manual.

Beneficiary liability "Add-on" messages should be printed in addition to denial and reduction messages for charges which the beneficiary is determined not liable. Liability "Add-on" messages should print for denials or reductions such as:

- Services that are part of another service or bundled code;
- Services determined not to be medically necessary in situations where the beneficiary was not notified in writing, prior to receipt of the service, that Medicare may not make payment;
- Duplicate charges; and
- Denials for utilization reasons.

50 - Categories and Identification Numbers for Approved MSN Messages

(Rev. 1, 10-01-03)

A3-3726.14A, B3-7014, PMs A-99-48, AB-02-106, B-02-047, AB-02-155, B-02-029

MSN messages are separated into the following categories. Within each category, messages are numbered beginning with 1 (e.g., ambulance messages are from 1.1 through 1.11; blood messages are from 2.1 through 2.2). Each MSN has a unique number when the category number is included. Numbers are the same for carriers and intermediaries, including DMERCs and RHHIs. However, the message number is not printed on the MSN, and contractors are free to use any internal numbering system appropriate for their systems.

Contractors are instructed to use the most appropriate message for each situation regardless of message category. The categories are to facilitate reference.

1 - Ambulance

2 - Blood

3 - Chiropractic

4 - End-Stage Renal Disease (ESRD)

5 - Number/Name/Enrollment

6 - Drugs

7 - Duplicate Bills

8 - Durable Medical Equipment (DME)

9 - Failure to Furnish Information

10 - Foot Care

11 - Transfer of Claims or Parts of Claims

12 - Hearing Aids

13 - Skilled Nursing Facility

14 - Laboratory

15 - Medical Necessity

16 - Miscellaneous

17 - Non Physician Services

18 - Preventive Care

19 - Hospital Based Physician Services

20 - Benefit Limits

21 - Restrictions to Coverage

22 - Split Claims

23 - Surgery

24 - “Help Stop Fraud” messages

25 - Time Limit for Filing

26 - Vision

27 - Hospice

28 - Mandatory Assignment for Physician Services Furnished Medicaid Patients

29 - Medicare Secondary Payer (MSP)

30 - Reasonable Charge and Fee Schedule

31 - Adjustments

32 - Overpayments/Offsets

33 - Ambulatory Surgical Centers

34 - Patient Paid/Split Payments

35 - Supplemental Coverage/Medigap

36 - Limitation of Liability

37 - Deductible/Coinsurance

38 - General Information

39 - Add-on Messages

40 - Mandated Messages

41 - Home Health Messages

42 - Religious Nonmedical Health Care Institutions

60 - Demonstration Project Messages

50.1 - Ambulance

(Rev. 1, 10-01-03)

1.1 - Payment for transportation is allowed only to the closest facility that can provide the necessary care.

1.2 - Payment is denied because the ambulance company is not approved by Medicare.

1.3 - Ambulance service to a funeral home is not covered.

1.4 - Transportation in a vehicle other than an ambulance is not covered.

1.5 - Transportation to a facility to be closer to home or family is not covered.

1.6 - This service is included in the allowance for the ambulance transportation.

1.7 - Ambulance services to or from a doctor’s office are not covered.

1.8 - This service is denied because you refused to be transported.

1.9 - Payment for ambulance services does not include mileage when you were not in the ambulance.

1.10 - Air ambulance is not covered since you were not taken to the airport by ambulance.

1.11 - The information provided does not support the need for an air ambulance. The approved amount is based on ground ambulance.

50.2 - Blood

(Rev. 1, 10-01-03)

2.1 - The first three pints of blood used in each year are not covered.

2.2 - Charges for replaced blood are not covered.

50.3 - Chiropractic

(Rev. 1, 10-01-03)

3.1 - This service is covered only when recent x-rays support the need for the service.

50.4 - End Stage Renal Disease (ESRD)

(Rev. 1, 10-01-03)

4.1 - This charge is more than Medicare pays for maintenance treatment of renal disease.

4.2 - This service is covered up to (insert appropriate number) months after transplant and release from the hospital.

4.3 - Prescriptions for immunosuppressive drugs are limited to a 30-day supply.

4.4 - Only one supplier per month may be paid for these supplies/services.

4.5 - Medicare pays the professional part of this charge to the hospital.

4.6 - Payment has been reduced by the number of days you were not in the usual place of treatment.

4.7 - Payment for all equipment and supplies is made through your dialysis center. They will bill Medicare for these services.

4.8 - This service cannot be paid because you did not choose an option for your dialysis equipment and supplies.

4.9 - Payment was reduced or denied because the monthly maximum allowance for this home dialysis equipment and supplies has been reached.

4.10 - No more than ($_____) can be paid for these supplies each month. (NOTE: Insert appropriate dollar amount.)

4.11 - The amount listed in the "You May Be Billed" column is based on the Medicare approved amount. You are not responsible for the difference between the amount charged and the amount charged and the approved amount.

50.5 - Name/Number/Enrollment

(Rev. 1, 10-01-03)

5.1 - Our records show that you do not have Medicare entitlement under the number shown on this notice. If you do not agree, please contact your local Social Security office.

5.2 - The name or Medicare number was incorrect or missing. Please check your Medicare card. If the information on this notice is different from your card, contact your provider.

5.3 - Our records show that the date of death was before the date of service.

5.4 - If you cash the enclosed check, you are legally obligated to make payment for these services. If you do not wish to assume this obligation, please return this check.

5.5 - Our records show you did not have Part A (B) coverage when you received this service. If you disagree, please contact us at the customer service number shown on this notice.

5.6 - The name or Medicare number was incorrect or missing. Ask your provider to use the name or number shown on this notice for future claims.

50.6 - Drugs

(Rev. 1, 10-01-03)

6.1 - This drug is covered only when Medicare pays for the transplant.

6.2 - Drugs not specifically classified as effective by the Food and Drug Administration are not covered.

6.3 - Payment cannot be made for oral drugs that do not have the same active ingredients as they would have if given by injection.

6.4 - Medicare does not pay for an oral anti-emetic drug that is not administered for use immediately before, at, or within 48 hours after administration of a Medicare covered chemotherapy drug.

6.5 - Medicare cannot pay for this injection because one or more requirements for coverage were not met.

50.7 - Duplicates

(Rev. 1, 10-01-03)

PMs B-02-047

7.1 - This is a duplicate of a charge already submitted.

7.2 - This is a duplicate of a claim processed by another contractor. You should receive a Medicare Summary Notice from them.

7.3 - This service/item is a duplicate of a previously processed service. No appeal rights are attached to the denial of this service except for the issue as to whether the service is a duplicate. Disregard the appeals information on this notice unless you are appealing whether the service is a duplicate.

50.8 - Durable Medical Equipment

(Rev. 308, Issued: 10-01-04, Effective: 10-01-04, Implementation: 10-04-04)

B-01-13, B-02-029

8.1 - Your supplier is responsible for the servicing and repair of your rented equipment.

8.2 - To receive Medicare payment, you must have a doctor's prescription before you rent or purchase this equipment.

8.3 - This equipment is not covered because its primary use is not for medical purposes.

8.4 - Payment cannot be made for equipment that is the same or similar to equipment already being used.

8.5 - Rented equipment that is no longer needed or used is not covered.

8.6 - A partial payment has been made because the purchase allowance has been reached. No further rental payments can be made.

8.7 - This equipment is covered only if rented.

8.8 - This equipment is covered only if purchased.

8.9 - Payment has been reduced by the amount already paid for the rental of this equipment.

8.10 - Payment is included in the approved amount for other equipment.

8.11 - The purchase allowance has been reached. If you continue to rent this piece of equipment, the rental charges are your responsibility.

8.12 - The approved charge is based on the amount of oxygen prescribed by the doctor.

8.13 - Monthly rental payments can be made for up to 15 months from the first paid rental month or until the equipment is no longer needed, whichever comes first.

8.14 - Your equipment supplier must furnish and service this item for as long as you continue to need it. Medicare will pay for maintenance and/or servicing for every 6-month period after the end of the 15th paid rental month.

8.15 - Maintenance and/or servicing of this item is not covered until 6 months after the end of the 15th paid rental month.

8.16 - Monthly allowance includes payment for oxygen and supplies.

8.17 - Payment for this item is included in the monthly rental payment amount.

8.18 - Payment is denied because the supplier did not have a written order from your doctor prior to delivery of this item.

8.19 - Sales tax is included in the approved amount for this item.

8.20- Medicare does not pay for this equipment or item.

8.21 - This item cannot be paid without a new, revised or renewed certificate of medical necessity.

8.22 - No further payment can be made because the cost of repairs has equaled the purchase price of this item.

8.23 - No payment can be made because the item has reached the 15-month limit. Separate payments can be made for maintenance or servicing every 6 months.

8.24 - The claim does not show that you own or are purchasing the equipment requiring these parts or supplies.

8.25 - Payment cannot be made until you tell your supplier whether you want to rent or buy this equipment.

8.26 - Payment is reduced by 25% beginning the 4th month of rental.

8.27 - Payment is limited to 13 monthly rental payments because you have decided to purchase this equipment.

8.28 - Maintenance, servicing, replacement, or repair of this item is not covered.

8.29 - Payment is allowed only for the seat lift mechanism, not the entire chair.

8.30 - This item is not covered because the doctor did not complete the certificate of medical necessity.

8.31 - Payment is denied because blood gas tests cannot be performed by a durable medical equipment supplier.

8.32 - This item can only be rented for 2 months. If the item is still needed, it must be purchased.

8.33 - This is the next to last payment for this item.

8.34 - This is the last payment for this item.

8.35 - This item is not covered when oxygen is not being used.

8.36 - Payment is denied because the certificate of medical necessity on file was not in effect for this date of service.

8.37 - An oxygen recertification form was sent to the physician.

8.38 - This item must be rented for 2 months prior to purchasing it.

8.39 - This is the 10th month of rental payment. Your supplier should offer you the choice of changing the rental to a purchase agreement.

8.40 - We have previously paid for the purchase of this item.

8.41 - Payment for the amount of oxygen supplied has been reduced or denied because the monthly limit has been reached.

8.42 - Standby equipment is not covered.

8.43 - Payment has been denied because this equipment cannot deliver the liters per minute prescribed by your doctor.

8.44 - Payment is based on a standard item because information did not support the need for a deluxe or more expensive item.

8.45 - Payment for electric wheelchairs is allowed only if the purchase decision is made in the first or tenth month of rental.

8.46 - Payment is included in the allowance for another item or service provided at the same time.

8.47 - Supplies or accessories used with noncovered equipment are not covered.

8.48 - Payment for this drug is denied because the need for the equipment has not been established.

8.49 - This allowance has been reduced because part of this item was paid on another claim.

8.50 - Medicare cannot pay for this drug/equipment because our records do not show your supplier is licensed to dispense prescription drugs, and, therefore, cannot assure the safety and effectiveness of the drug/equipment. You are not financially liable for any amount for this drug/equipment unless your supplier gave you a written notice in advance that Medicare would not pay for it and you agreed to pay.

8.51 - You are not liable for any additional charge as a result of receiving an upgraded item.

8.52 - You signed an Advanced Beneficiary Notice (ABN). You are responsible for the difference between the upgrade amount and the Medicare payment.

8.53 - This item or service was denied because the upgrade information was invalid.

8.57 - Your equipment supplier must furnish and service this item for as long as you continue to need it. Medicare will pay for maintenance and/or servicing for every 3 month period after the end of the 15th paid rental month.

8.58 - No payment can be made because the item has reached the 15 month limit. Separate payments can be made for maintenance or servicing every 3 months.

50.9 - Failure to Furnish Information

(Rev. 1, 10-01-03)

9.1 - The information we requested was not received.

9.2 - This item or service was denied because information required to make payment was missing.

9.3 - Please ask your provider to submit a new, complete claim to us. (NOTE: Add-on to other messages as appropriate)

9.4 - This item or service was denied because information required to make payment was incorrect.

9.5 - Our records show your doctor did not order this supply or amount of supplies.

9.6 - Please ask your provider to resubmit this claim with a breakdown of the charges or services.

9.7 - We have asked your provider to resubmit the claim with the missing or correct information. (NOTE: Add-on to other messages as appropriate.)

9.8 - The hospital has been asked to submit additional information, you should not be billed at this time.

9.9 - This service is not covered unless the supplier files an electronic media claim (EMC).

50.10 - Foot Care

(Rev. 1, 10-01-03)

10.1 - Shoes are only covered as part of a leg brace.

50.11 - Transfer of Claims

(Rev. 1, 10-01-03)

B3-3110, Rev. 1751

11.1 - Your claim has been forwarded to the correct Medicare contractor for processing. You will receive a notice from them. (NOTE: Use for carriers, intermediaries, RRB, United Mine Workers.)

11.2 - This information is being sent to Medicaid. They will review it to see if additional benefits can be paid.

11.3 - Our records show that you are enrolled in a health maintenance organization. Your provider must bill this service to them.

11.4 - Our records show that you are enrolled in a health maintenance organization. Your claim was sent to them for processing.

11.5 - This claim will need to be submitted to (another carrier, a durable medical equipment regional carrier (DMERC), Medicaid agency).

11.6 - We have asked your provider to resubmit this claim to the proper carrier (intermediary). That carrier (intermediary) is (name and address of carrier, intermediary or durable medical equipment regional carrier, etc.)

11.7 - This claim/service is not payable under our claims jurisdiction area. We have notified your provider that they must forward the claim/service to the correct carrier for processing.

11.9 - This claim/service is not payable under our claims jurisdiction. We have notified your provider to send your claim for these services to the Railroad Retirement Board Medicare carrier.

50.12 - Hearing Aids

(Rev. 1, 10-01-03)

12.1 - Hearing aids are not covered.

50.13 - Skilled Nursing Facility

(Rev. 1, 10-01-03)

PMs AB-01-169, B-00-67

13.1 - No qualifying hospital stay dates were shown for this skilled nursing facility stay.

13.2 - Skilled nursing facility benefits are only available after a hospital stay of at least 3 days.

13.3 - Information provided does not support the need for skilled nursing facility care.

13.4 - Information provided does not support the need for continued care in a skilled nursing facility.

13.5 - You were not admitted to the skilled nursing facility within 30 days of your hospital discharge.

13.6 - Rural primary care skilled nursing facility benefits are only available after a hospital stay of at least 2 days. (NOTE: This message is used only in connection with hospital stays that occurred prior to October 1, 1997).

13.7 - Normally, care is not covered when provided in a bed that is not certified by Medicare. However, since you received covered care, we have decided that you will not have to pay the facility for anything more than Medicare coinsurance and noncovered items.

13.8 - The skilled nursing facility should file a claim for Medicare benefits because you were an inpatient.

13.9 - Medicare Part B does not pay for this item or service since our records show that you were in a skilled nursing facility on this date.

50.14 - Laboratory

(Rev. 1, 10-01-03)

14.1 - The laboratory is not approved for this type of test.

14.2 - Medicare approved less for this individual test because it can be done as part of a complete group of tests.

14.3 - Services or items not approved by the Food and Drug Administration are not covered.

14.4 - Payment denied because the claim did not show who performed the test and/or the amount charged.

14.5 - Payment denied because the claim did not show if the test was purchased by the physician or if the physician performed the test.

14.6 - This test must be billed by the laboratory that did the work.

14.7 - This service is paid at 100% of the Medicare approved amount. (NOTE: Mandated message - This message must appear on all service lines paid at 100% of the Medicare approved amount.)

14.8 - Payment cannot be made because the physician has a financial relationship with the laboratory.

14.9 - Medicare cannot pay for this service for the diagnosis shown on the claim.

14.10 - Medicare does not allow a separate payment for EKG readings.

14.11 - A travel allowance is paid only when a covered specimen collection fee is billed.

14.12 - Payment for transportation can only be made if an x-ray or EKG is performed.

14.13 - The laboratory was not approved for this test on the date it was performed.

50.15 - Medical Necessity

(Rev. 227, Issued 07-09-04) (Effective: February 3, 2004/Implementation: August 9, 2004)

15.1 - The information provided does not support the need for this many services or items.

15.2 - The information provided does not support the need for this equipment.

15.3 - The information provided does not support the need for the special features of this equipment.

15.4 - The information provided does not support the need for this service or item.

15.5 - The information provided does not support the need for similar services by more than one doctor during the same time period.

15.6 - The information provided does not support the need for this many services or items within this period of time.

15.7 - The information provided does not support the need for more than one visit a day.

15.8 - The information provided does not support the level of service as shown on the claim.

15.9 - The Quality Improvement Organization did not approve this service.

15.10 - Medicare does not pay for more than one assistant surgeon for this procedure.

15.11 - Medicare does not pay for an assistant surgeon for this procedure/surgery.

15.12 - Medicare does not pay for two surgeons for this procedure.

15.13 - Medicare does not pay for team surgeons for this procedure.

15.14 - Medicare does not pay for acupuncture.

15.15 - Payment has been reduced because information provided does not support the need for this item as billed.

15.16 - Your claim was reviewed by our medical staff. (NOTE: Add-on to other messages as appropriate.)

15.17 - We have approved this service at a reduced level. (NOTE: Add-on to other messages as appropriate.)

15.18 - Medicare does not cover this service at home.

15.19 - A local medical review policy (LMRP) *or local coverage determination (LCD)* was used when we made this decision. An LMRP*/LCD* provides a guide to assist in determining whether a particular item or service is covered by Medicare. A copy of this policy is available from your local intermediary or carrier by calling the number in the customer service information box on page one. You can compare the facts in your case to the guidelines set out in the LMRP*/LCD* to see whether additional information from your physician would change our decision.

15.20 - The following policies [insert LMRP/LCD ID #(s) and NCD #(s)] were used when we made this decision.

50.16 - Miscellaneous

(Rev. 1, 10-01-03)

PMs B-01-10, AB-01-79, A-01-69, A-01-132, B-01-21

16.1 - This service cannot be approved because the date on the claim shows it was billed before it was provided.

16.2 - This service cannot be paid when provided in this location/facility.

16.3 - The claim did not show that this service or item was prescribed by your doctor.

16.4 - This service requires prior approval by the Quality Improvement Organization.

16.5 - This service cannot be approved without a treatment plan by a physical or occupational therapist.

16.6 - This item or service cannot be paid unless the provider accepts assignment.

16.7 - Your provider must complete and submit your claim.

16.8 - Payment is included in another service received on the same day.

16.9 - This allowance has been reduced by the amount previously paid for a related procedure.

16.10 - Medicare does not pay for this item or service.

16.11 - Payment was reduced for late filing. You cannot be billed for the reduction. (NOTE: Mandated message - This message must print on all service lines subject to the 10% reduction.)

16.12 - Outpatient mental health services are paid at 50% of the approved charges. (NOTE: Mandated message - This message must print on all service lines subject to the outpatient psychiatric reduction when no deductible has been applied.)

16.13 - The code(s) your provider used is/are not valid for the date of service billed.

16.14 - The attached check replaces your previous check (#____) dated (_____).

16.15 - The attached check replaces your previous check. (NOTE: Use only if prior check information is not accessible by the system.)

16.16 - As requested, this is a duplicate copy of your Medicare Summary Notice.

16.17 - Medicare does not pay for these services when they are not given in conjunction with total parenteral nutrition.

16.18 - Service provided prior to the onset date of certified parenteral/enteral nutrition therapy is not covered.

16.19 - The approved amount of this parenteral/enteral nutrition supply is based on a less extensive level of care for the nature of the diagnosis stated.

16.20 - The approved payment for calories/grams is the most Medicare may allow for the diagnosis stated.

16.21 - The procedure code was changed to reflect the actual service rendered.

16.22 - Medicare does not pay for services when no charge is indicated.

16.23 - This check is for the excess amount you paid toward a prior overpayment.

16.24 - Services provided aboard a ship are covered only when the ship is of United States registry and is in United States waters. In addition, the service must be provided by a doctor licensed to practice in the United States.

16.25 - Medicare does not pay for this much equipment, or this many services or supplies.

16.26 - Medicare does not pay for services or items related to a procedure that has not been approved or billed.

16.27 - This service is not covered since our records show you were in the hospital at this time.

16.28 - Medicare does not pay for services or equipment that you have not received.

16.29 - Payment is included in another service you have received.

16.30 - Services billed separately on this claim have been combined under this procedure.

16.31 - You are responsible to pay the primary physician care the agreed monthly charge.

16.32 - Medicare does not pay separately for this service.

16.33 - Your payment includes interest because Medicare exceeded processing time limits. (NOTE: Mandated message - This message must print claim level if interest is added into the beneficiary payment amount for unassigned or split pay claims.)

16.35 - You do not have to pay this amount. (NOTE: Add-on to other messages as appropriate.)

16.37 - Please see the back of this notice. (NOTE: Add-on to other messages as you feel appropriate.)

16.38 - Charges are not incurred for leave of absence days.

16.39 - Only one provider can be paid for this service per calendar month. Payment has already been made to another provider for this service.

16.40 - Only one inpatient service per day is allowed.

16.41 - Payment is being denied because you refused to request reimbursement under your Medicare benefits.

16.42 - The provider's determination of noncoverage is correct.

16.43 - This service cannot be approved without a treatment plan and supervision of a doctor.

16.44 - Routine care is not covered.

16.45 - You cannot be billed separately for this item or service. You do not have to pay this amount.

16.46 - Medicare payment limits do not affect a Native American's right to free care at Indian Health Institutions.

16.47 - When deductible is applied to outpatient psychiatric services, you may be billed for up to the approved amount. The "You May Be Billed" column will tell you the correct amount to pay your provider.

16.48 - Medicare does not pay for this item or service for this condition.

16.49 - This claim/service is not covered because alternative services were available, and should have been utilized.

16.50 - The doctor or supplier may not bill more than the Medicare allowed amount.

16.51 - This service is not covered prior to July 1, 2001.

16.52 - This service was denied because coverage for this service is provided only after a documented failed trial of pelvic muscle exercise training.

16.53 - The amount Medicare paid the provider for this claim is ($_____).

16.54 - This service is not covered prior to January 1, 2002.

50.17 - Nonphysician Services

(Rev. 1, 10-01-03)

AB-03-057

17.1 - Services performed by a private duty nurse are not covered.

17.2 - This anesthesia service must be billed by a doctor.

17.3 - This service was denied because you did not receive it under the direct supervision of a doctor.

17.4 - Services performed by an audiologist are not covered except for diagnostic procedures.

17.5 - Your provider's employer must file this claim and agree to accept assignment.

17.6 - Full payment was not made for this service(s) because the yearly limit has been met.

17.7 - This service must be performed by a licensed clinical social worker.

17.8 - Payment was denied because the maximum benefit allowance has been reached.

17.9 - Medicare (Part A/Part B) pays for this service. The provider must bill the correct Medicare contractor. (NOTE: Insert appropriate program. Message is used for Part A claims received by Part B or Part B claims received by Part A.)

17.10 - The allowance has been reduced because the anesthesiologist medically directed concurrent procedures.

17.11 - This item or service cannot be paid as billed.

17.12 - This service is not covered when provided by an independent therapist.

17.13 - Medicare approves a limited dollar amount each year for physical therapy and speech-language pathology services and a separate limit each year for occupational therapy services when billed by providers, physical and occupational therapists, physicians, and other non-physician practitioners. Medically necessary therapy over these limits is covered when received at a hospital outpatient department. (NOTE: Insert appropriate dollar amount.)

17.14 - Charges for maintenance therapy are not covered.

17.15 - This service cannot be paid unless certified by your physician every (___) days. (NOTE: Insert appropriate number of days.)

17.16 - The hospital should file a claim for Medicare benefits because these services were performed in a hospital setting.

17.18 - ($) has been applied during this calendar year (CCYY) towards the ($) limit on outpatient physical therapy and speech-language pathology benefits.

17.19 - ($) has been applied during this calendar year (CCYY) towards the ($) limit on outpatient occupational therapy benefits

50.18 - Preventive Care

(Rev.298, Issued: 09-10-04, Effective/Implementation: 09-25-04)

AB-02-010

18.1 - Routine examinations and related services not covered.

18.2 - This immunization and/or preventive care is not covered.

18.3 - Screening mammography is not covered for women *under*35 years of age.

18.4 - This service is being denied because it has not been 12 months since your last examination of this kind. (NOTE: Insert appropriate number of months.)

18.6 - A screening mammography is covered only once for women age 35 - 39.

18.7 - Screening pap smears are covered only once every 24 months unless high risk factors are present.

18.12 - Screening mammograms are covered annually for women 40 years of age and older.

18.13 - This service is not covered for beneficiaries under 50 years of age.

18.14 - Service is being denied because it has not been (12, 24, 48) months since your last (test/procedure) of this kind.

18.15 - Medicare only covers this procedure for beneficiaries considered to be at high risk for colorectal cancer.

18.16 - This service is being denied because payment has already been made for a similar procedure within a set time frame.

18.17 - Medicare pays for a screening Pap smear and a screening pelvic examination once every 2 years unless high risk factors are present.

18.18 - Medicare does not pay for this service separately since payment of it is included in our allowance for other services you received on the same day.

18.19 - This service is not covered until after the beneficiary's 50th birthday

50.19 - Hospital Based Physicians

(Rev. 1, 10-01-03)

19.1 - Services of a hospital-based specialist are not covered unless there is an agreement between the hospital and the specialist.

19.2 - Payment was reduced because this service was performed in a hospital outpatient setting rather than a provider's office.

19.3 - Only one hospital visit or consultation per provider is allowed per day.

50.20 - Benefit Limits

(Rev. 1, 10-01-03)

AB-02-151

20.1 - You have used all of your benefit days for this period.

20.2 - You have reached your limit of 190 days of psychiatric hospital services.

20.3 - You have reached your limit of 60 lifetime reserve days.

20.4 - (___) of the Benefit Days Used were charged to your Lifetime Reserve Day benefit. (NOTE: Mandated message - This message must be printed claim level when all or a portion of the Benefit Days Used are charged to the Lifetime Reserve Day benefit.)

20.5 - These services cannot be paid because your benefits are exhausted at this time.

20.6 - Days used has been reduced by the primary group insurer's payment.

20.7 - You have (___) day(s) remaining of your 190-day psychiatric limit.

20.8 - Days used are being subtracted from your total (inpatient or skilled nursing facility) benefits for this benefit period.

20.9 - Services after (mm/dd/yy) cannot be paid because your benefits were exhausted.

20.10 - This service was denied because Medicare only pays up to 10 hours of diabetes education training during the initial 12-month period. Our records show you have already obtained 10 hours of training.

20.11 - This service was denied because Medicare pays for two hours of follow up diabetes education training during a calendar year. Our records show you have already obtained two hours of training for this calendar year.

20.13 - This service was denied because Medicare only pays up to three hours of medical nutrition therapy during a calendar year. Our records show you have already received three hours of medical nutrition therapy.

20.14 - This service was denied because Medicare only pays two hours of follow-up for medical nutrition therapy during a calendar year. Our records show you have already received two hours of follow-up services for this calendar year.

50.21 - Restriction to Coverage

(Rev. 1, 10-01-03)

21.1 - Services performed by an immediate relative or a member of the same household are not covered.

21.2 - The provider of this service is not eligible to receive Medicare payments.

21.3 - This provider was not covered by Medicare when you received this service.

21.4 - Services provided outside the United States are not covered. See your Medicare Handbook for services received in Canada and Mexico.

21.5 - Services needed as a result of war are not covered.

21.6 - This item or service is not covered when performed, referred or ordered by this provider.

21.7 - This service should be included on your inpatient bill.

21.8 - Services performed using equipment that has not been approved by the Food and Drug Administration are not covered.

21.9 - Payment cannot be made for unauthorized service outside the managed care plan.

21.10 - A surgical assistant is not covered for this place and/or date of service.

21.11 - This service was not covered by Medicare at the time you received it.

21.12 - This hospital service was not covered because the attending physician was not eligible to receive Medicare benefits at the time the service was performed.

21.13 - This surgery was not covered because the attending physician was not eligible to receive Medicare benefits at the time the service was performed.

21.14 - Medicare cannot pay for this investigational device because the FDA clinical trial period has not begun.

21.15 - Medicare cannot pay for this investigational device because the FDA clinical trial period has ended.

21.16 - Medicare does not pay for this investigational device.

21.17 - Your provider submitted noncovered charges for which you are responsible.

21.18 - This item or service is not covered when performed or ordered by this provider.

21.19 - This provider decided to dropout of Medicare. No payment can be made for this service, you are responsible for this charge. Under Federal law, your doctor cannot charge you more than the limiting charge amount.

21.20 - This provider decided to dropout of Medicare. No payment can be made for this service; you are responsible for this charge.

21.21 - This service was denied because Medicare only covers this service under certain circumstances.

21.22 - Medicare does not pay for this service because it is considered investigational and/or experimental in these circumstances.

50.22 - Split Claims

(Rev. 1, 10-01-03)

22.1 - Your claim was separated for processing. The remaining services may appear on a separate notice. (NOTE: Mandated message - This message must print claim level on all split claims, including the original and replicate claim.)

50.23 - Surgery

(Rev. 1, 10-01-03)

23.1 - The cost of care before and after the surgery or procedure is included in the approved amount for that service.

23.2 - Cosmetic surgery and related services are not covered.

23.3 - Medicare does not pay for surgical supports except primary dressings for skin grafts.

23.4 - A separate charge is not allowed because this service is part of the major surgical procedure.

23.5 - Payment has been reduced because a different doctor took care of you before and/or after the surgery.

23.6 - This surgery was reduced because it was performed with another surgery on the same day.

23.7 - Payment cannot be made for an assistant surgeon in a teaching hospital unless a resident doctor was not available.

23.8 - This service is not payable because it is part of the total maternity care charge.

23.9 - Payment has been reduced because the charges billed did not include post-operative care.

23.10 - Payment has been reduced because this procedure was terminated before anesthesia was started.

23.11 - Payment cannot be made because the surgery was canceled or postponed.

23.12 - Payment has been reduced because the surgery was canceled after you were prepared for surgery.

23.13 - Because you were prepared for surgery and anesthesia was started, full payment is being made even though the surgery was canceled.

23.14 - The assistant surgeon must file a separate claim for this service.

23.15 - The approved amount is less because the payment is divided between two doctors. (NOTE: Use for global reductions.)

23.16 - An additional amount is not allowed for this service when it is performed on both the left and right sides of the body.

50.24 - Fraud and Abuse Section (Help Stop Fraud)

(Rev. 1, 10-01-03)

PM AB-02-106

24.1 - Protect your Medicare number as you would a credit card number.

24.2 - Beware of telemarketers or advertisements offering free or discounted Medicare items and services.

24.3 - Beware of door-to-door solicitors offering free or discounted Medicare items or services.

24.4 - Only your physician can order medical equipment for you.

24.5 - Always review your Medicare Summary Notice for correct information about the items or services you received.

24.6 - Do not sell your Medicare number or Medicare Summary Notice.

24.7 - Do not accept free medical equipment you do not need.

24.8 - Beware of advertisements that read, “This item is approved by Medicare”, or “No out-of-pocket expenses.”

24.10 - Always read the front and back of your Medicare Summary Notice.

24.11 - Beware of Medicare scams, such as offers of free milk or cheese for your Medicare number.

24.12 - Read your Medicare Summary Notice carefully for accuracy of dates, services, and amounts billed to Medicare.

24.13 - Be sure you understand anything you are asked to sign.

24.14 - Be sure any equipment or services you received were ordered by your doctor.

50.25 - Time Limit for Filing

(Rev. 1, 10-01-03)

25.1 - This claim was denied because it was filed after the time limit.

25.2 - You can be billed only 20% of the charges that would have been approved.

50.26 - Vision

(Rev. 1, 10-01-03)

26.1 - Eye refractions are not covered.

26.2 - Eyeglasses or contact lenses are only covered after cataract surgery or if the natural lens of your eye is missing.

26.3 - Only one pair of eyeglasses or contact lenses is covered after cataract surgery with lens implant.

26.4 - This service is not covered when performed by this provider.

26.5 - This service is covered only in conjunction with cataract surgery.

26.6 - Payment was reduced because the service was terminated early.

50.27 - Hospice

(Rev. 1, 10-01-03)

27.1 - This service is not covered because you are enrolled in a hospice.

27.2 - Medicare will not pay for inpatient respite care when it exceeds five consecutive days at a time.

27.3 - The physician certification requesting hospice services was not received timely.

27.4 - The documentation received indicates that the general inpatient care level of services were not necessary for care related to the terminal illness. Therefore, payment will be adjusted to the routine home care rate.

27.5 - Payment for the day of discharge from the hospital will be made to the hospice agency at the routine home care rate.

27.6 - The documentation indicates the level of care was at the respite level not the general inpatient level of care. Therefore, payment will be adjusted to the respite care rate.

27.7 - According to Medicare hospice requirements, the hospice election consent was not signed timely.

27.8 - The documentation submitted does not support that your illness is terminal.

27.9 - The documentation indicates your inpatient level of care was not reasonable and necessary. Therefore, payment will be adjusted to the routine home care rate.

27.10 - The documentation indicates that the indicates that the service level of continuous home care was not reasonable and necessary. Therefore, payment will be adjusted to the routine home care rate.

27.11 - The provider has billed in error for the routine home care items or services received.

27.12 - The documentation indicates your level of care was not reasonable and necessary. Therefore, payment will be adjusted to the routine home care rate.

27.13 - According to Medicare hospice requirements, this service is not covered because the service was provided by a non-attending physician.

50.28 - Mandatory Assignment for Physician Services Furnished for Medicaid Patients

(Rev. 1, 10-01-03)

28.1 - Because you have Medicaid, your provider must agree to accept assignment.

50.29 - Medicare Secondary Payer (MSP)

(Rev. 1, 10-01-03)

29.1 - Secondary payment cannot be made because the primary insurer information was either missing or incomplete.

29.2 - No payment was made because your primary insurer's payment satisfied the provider's bill.

29.3 - Medicare benefits are reduced because some of these expenses have been paid by your primary insurer.

29.4 - In the future, if you send claims to Medicare for secondary payment, please send them to (carrier MSP address).

29.5 - Our records show that Medicare is your secondary payer. This claim must be sent to your primary insurer first. (NOTE: Use Add-on message as appropriate.)

29.6 - Our records show that Medicare is your secondary payer. Services provided outside your prepaid health plan are not covered. We will pay this time only since you were not previously notified.

29.7 - Medicare cannot pay for this service because it was furnished by a provider who is not a member of your employer prepaid health plan. Our records show that you were informed of this rule.

29.8 - This claim is denied because the service(s) may be covered by the worker's compensation plan. Ask your provider to submit a claim to that plan.

29.9 - Since your primary insurance benefits have been exhausted, Medicare will be primary on this accident related service.

29.10 - These services cannot be paid because you received them on or before you received a liability insurance payment for this injury or illness.

29.11 - Our records show that an automobile medical, liability, or no-fault insurance plan is primary for these services. Submit this claim to the primary payer. (NOTE: Use Add-on message as appropriate.)

29.12 - Our records show that these services may be covered under the Black Lung Program. Contact the Federal Black Lung Program, P.O. Box 828, Lanham-Seabrook, MD 20703-0828. (NOTE: Use Add-on message as appropriate.)

29.13 - Medicare does not pay for these services because they are payable by another government agency. Submit this claim to that agency. (NOTE: Use Add-on message as appropriate.)

29.14 - Medicare's secondary payment is ($_____). This is the difference between the primary insurer's approved amount of ($_____) and the primary insurer's paid amount of ($_____). (NOTE: Mandated message - This message should print service level when a Medicare secondary payment is made and the primary insurer's approved amount is higher than Medicare's approved amount. Do not print when the claim paid amount is equal to the amount Medicare would pay if services were not covered by a third party payer. This message should print claim level for MSNs containing claims or adjustments having the Medicare secondary payment calculated at the claim level.)

29.15 - Medicare's secondary payment is ($_____). This is the difference between Medicare's approved amount of ($_____) and the primary insurer's paid amount of ($_____). (NOTE: Mandated message - This message should print claim service when a Medicare secondary payment is made and Medicare's approved amount is higher than the primary insurer's approved amount. Do not print when the claim paid amount is equal to the amount Medicare would pay if services were not covered by a third party payer. This message should print claim level for MSNs containing claims or adjustments having the Medicare secondary payment calculated at the claim level.)

29.16 - Your primary insurer approved and paid ($_____) on this claim. Therefore, no secondary payment will be made by Medicare. (NOTE: Mandated message - This message should print service level when the primary insurer's approved amount is higher than Medicare's approved amount and the primary payment is equal to the approved amount. Do not print on denied service lines. This message should print claim level for MSNs containing claims or adjustments having the Medicare secondary payment calculated at the claim level. Print either "claim" or "service" in the message as applicable. Do not print "claim/service".)

29.17 - Your provider agreed to accept ($_____) as payment in full on this (claim/service). Your primary insurer has already paid ($_____) so Medicare's payment is the difference between the two amounts. (NOTE: Mandated message - This message should print service level when the provider is obligated to accept less than the Medicare approved amount. Print the message at the claim level for MSNs containing claims or adjustments having the Medicare secondary payment calculated at the claim level. Print either "claim" or "service" in the message as applicable. Do not print "claim/service.")

29.18 - The amount listed in the "You May Be Billed" column assumes that your primary insurer paid the provider. If your primary insurer paid you, then you are responsible to pay the provider the amount your primary insurer paid to you plus the amount in the "You May Be Billed" column. (NOTE: Mandated message - This message should print on all assigned MSP service lines when Medicare secondary payment was made. Print message on assigned service lines for full recoveries. Do not print on denied service lines.)

29.19 - The amount listed in the "You May Be Billed" column assumes that your primary insurer paid you. If your primary insurer paid the provider, then you only need to pay the provider the difference between the amount charged and the amount the primary insurer paid. (NOTE: Mandated message - This message should print on all unassigned MSP service lines when Medicare secondary payment was made. Print message on unassigned service lines for full recoveries. Do not print on denied service lines. Do not print when conditions in 29.20 or 29.22 are met.)

29.20 - The amount listed in the "You May Be Billed" column assumes that your primary insurer paid you. If your primary insurer paid the provider, then you only need to pay the provider the difference between the amounts the provider agreed to accept and the amount the primary insurer paid. (NOTE: This message should print on all unassigned MSP service lines when the provider is obligated to accept less than the Medicare approved amount. Do not print on denied service lines.)

29.21 - The amount listed in the "You May Be Billed" column assumes that your primary insurer made no payment for this service. If your primary insurer did make payment for this service, the amount you may be billed is the difference between the amount charged and the primary insurer's payment. (NOTE: Mandated message - This message should print on all Medicare disallowed services for which the beneficiary is liable and the service has been submitted on a claim indicating there has been a primary insurer payment made.)

29.22 - The amount listed in the "You May Be Billed" column assumes that your primary insurer paid you. If your primary insurer paid the provider, then you only need to pay the provider the difference between the amount the provider can legally charge and the amount the primary insurer paid. See note (__) for the legal charge limit. (NOTE: This message should print on all unassigned MSP service lines when a Medicare secondary payment is made and the provider has exceeded the limiting charge.)

29.23 - No payment can be made because payment was already made by either worker's compensation or the Federal Black Lung Program.

29.24 - No payment can be made because payment was already made by another government entity.

29.25 - Medicare paid all covered services not paid by other insurer.

29.26 - The primary payer is _____. (NOTE: Add-on to messages as appropriate and/or as your system permits.)

29.27 - Your primary group's payment satisfied Medicare deductible and coinsurance.

29.28 - Your responsibility on this claim has been reduced by the amount paid by your primary insurer.

29.29 - Your provider is allowed to collect a total of ($_____) on this claim. Your primary insurer paid ($_____) and Medicare paid ($_____). You are responsible for the unpaid portion of ($_____).

29.30 - ($_____) of the money approved by your primary insurer has been credited to your Medicare Part B (A) deductible. You do not have to pay this amount.

29.31 - Resubmit this claim with the missing or correct information.

29.32 - Medicare's secondary payment is ($_____). This is the difference between Medicare's limiting charge amount of ($_____) and the primary insured's paid amount of ($_____) (NOTE: Mandated message - This message should print service level when the Medicare secondary payment is the difference between the limiting charge amount and the primary insurer's paid amount.)

NOTE: Please refer to the exhibits for examples of MSP messages.

50.30 - Reasonable Charge and Fee Schedule

(Rev. 1, 10-01-03)

30.1 - The approved amount is based on a special payment method.

30.2 - The facility fee allowance is greater than the billed amount.

30.3 - Your doctor did not accept assignment for this service. Under Federal law, your doctor cannot charge more than ($_____). If you have already paid more than this amount, you are entitled to a refund from the provider. (NOTE: This message should print on all unassigned service lines for which the billed amount exceeds the Medicare limiting charge. Do not print when the amount the limiting charge is exceeded is less than any threshold established by CMS.)

30.4 - A change in payment methods has resulted in a reduced or zero payment for this procedure.

30.5 - This amount is the difference in billed amount and Medicare approved amount.

50.31 - Adjustments

(Rev. 1, 10-01-03)

NOTE: You must print at least one of the messages in this section for all adjusted claims shown on the MSN.

31.1 - This is a correction to a previously processed claim and/or deductible record.

31.2 - A payment adjustment was made based on a telephone review.

31.3 - This notice is being sent to you as the result of a reopening request.

31.4 - This notice is being sent to you as the result of a fair hearing request.

31.5 - If you do not agree with the Medicare approved amount(s) and $100 or more is in dispute (less deductible and coinsurance), you may ask for a hearing. You must request a hearing within 6 months of the date of this notice. To meet the limit you may combine amounts on other claims that have been reviewed. At the hearing, you may present any new evidence which could affect the decision. Call us at the number in the Customer Service block if you need more information about the hearing process.

31.6 - A payment adjustment was made based on a Quality Improvement Organization request.

31.7 - This claim was previously processed under an incorrect Medicare claim number or name. Our records have been corrected.

31.8 - This claim was adjusted to reflect the correct provider.

31.9 - This claim was adjusted because there was an error in billing.

31.10 - This is an adjustment to a previously processed charge (s). This notice may not reflect the charges as they were originally submitted.

31.11 - The previous notice we sent stated that your doctor could not charge more than ($_____). This additional payment allows your doctor to bill you the full amount charged. (NOTE: Mandated message - This message should print service level, as appropriate, when limiting charge applies.)

31.12 - The previous notice we sent stated the amount you could be charged for this service. This additional payment changed that amount. Your doctor cannot charge you

more than ($_____). (NOTE: Mandated message - This message should print service level, as appropriate, when limiting charge applies.)

31.13 - The Medicare paid amount has been reduced by ($_____) previously paid for this claim. (NOTE: Mandated message - This message should print claim level on all adjustments for which a partial payment was previously made.)

31.14 - This payment is the result of an Administrative Law Judge's decision.

31.15 - An adjustment was made based on a review decision.

31.16 - An adjustment was made based on a reconsideration.

31.17 - This is an internal adjustment. No action is required on your part.

50.32 - Overpayments/Offsets

(Rev. 1, 10-01-03)

32.1 - ($_____) dollars of this payment has been withheld to recover a previous overpayment. (NOTE: Mandated message - This message should print claim level when the beneficiary check amount is reduced to recover a previous overpayment. Fill in the blank with the amount withheld on the claim at issue.)

32.2 - You should not be billed separately by your physician(s) for services provided during this inpatient stay.

50.33 - Ambulatory Surgical Care

(Rev. 1, 10-01-03)

33.1 - The ambulatory surgical center must bill for this service.

50.34 - Patient Paid/Split Payment

(Rev. 1, 10-01-03)

B-01-21

34.1 - Of the total ($_____) paid on this claim, we are paying you ($_____) because you paid your provider more than your 20% coinsurance on Medicare approved services. The remaining ($_____) was paid to the provider. (NOTE: Mandated message - This message should print claim level on all assigned claims generating payment to the beneficiary.)

34.2 - The amount in the "You May Be Billed" column has been reduced by the amount you paid the provider at the time the services were rendered. (NOTE: Mandated message - This message should print claim level on all assigned claims with a beneficiary paid

amount that does not exceed coinsurance and deductible and for all unassigned claims submitted with a beneficiary paid amount.)

34.3 - After applying Medicare guidelines and the amount you paid to the provider at the time the services were rendered, our records indicate you are entitled to a refund. Please contact your provider. (NOTE: Mandated message - This message should print claim level on assigned claims with a split payment to the beneficiary under $1.00.) (NOTE: Use this message only when your system cannot plug the dollar amount in message 34.8.)

34.4 - We are paying you ($_____) because the amount you paid the provider was more than you may be billed for Medicare approved charges.

34.5 - The amount owed you is ($_____). Medicare does not routinely issue checks for amounts under $1.00. This amount due will be included in your next check. If you want this money issued immediately, please contact us at the address or phone number in the Customer Service Information box.

34.6 - Your check includes ($_____) which was withheld on a prior claim.

34.7 - This check includes an amount less than $1.00 that was withheld on a prior claim. (NOTE: Use this message only when your system cannot plug the dollar amount in message 34.6.)

34.8 - The amount you paid the provider for this claim was more than the required payment. You should be receiving a refund of ($_____) from your provider, which is the difference between what you paid and what you should have paid. (NOTE: Mandated message - This message should print claim level on assigned claims with a split payment to the beneficiary under $1.00.)

34.9 - If you already paid the supplier/provider, the supplier must refund any amount that exceeds the Medicare approved amount.

50.35 - Supplemental Coverage/Medigap

(Rev. 1, 10-01-03)

35.1 - This information is being sent to your private insurer(s). Send any questions regarding your benefits to them. (NOTE: Add if possible. "Your private insurer(s) is/are _____.)"

35.2 - We have sent your claim to your Medigap insurer. Send any questions regarding your benefits to them. (NOTE: Add if possible: "Your Medigap insurer is _____.)"

35.3 - A copy of this notice will not be forwarded to your Medigap insurer because the information was incomplete or invalid. Please submit a copy of this notice to your Medigap insurer.

35.4 - A copy of this notice will not be forwarded to your Medigap insurer because your provider does not participate in the Medicare program. Please submit a copy of this notice to your Medigap insurer.

35.5 - We did not send this claim to your private insurer. They have indicated no additional payment can be made. Send any questions regarding your benefits to them.

35.6 - Your supplemental policy is not a Medigap policy under Federal and State law or regulation. It is your responsibility to file a claim directly with your insurer.

35.7 - Please do not submit this notice to them (Add-on to other messages as appropriate.)

50.36 - Limitation of Liability

(Rev. 1, 10-01-03)

36.1 - Our records show that you were informed in writing, before receiving the service, that Medicare would not pay. You are liable for this charge. If you do not agree with this statement, you may ask for a review.

36.2 - It appears that you did not know that we would not pay for this service, so you are not liable. Do not pay your provider for this service. If you have paid your provider for this service, you should submit to this office three things: (1) a copy of this notice, (2) your provider's bill, and (3) a receipt or proof that you have paid the bill. You must file your written request for payment within 6 months of the date of this notice. Future services of this type provided to you will be your responsibility.

36.3 - Your provider has been notified that you are due a refund if you paid for this service. If you do not receive a refund from the provider within 30 days from your receipt of this notice, please write our office and include a copy of this notice. Your provider has the right to appeal this decision, which may change your right to a refund.

36.4 - This payment refunds the full amount you paid to your provider for the services previously processed and denied. You are entitled to this refund because your provider did not tell you in writing before providing the service(s) that Medicare would not pay for the denied service (s). In the future, you will have to pay for this service when it is denied.

36.5 - This payment refunds the full amount you are entitled to for services previously processed and reduced. You are entitled to this refund because your provider did not tell you in writing before providing the service (s) that Medicare would approve it at a lower amount. In the future, you will have to pay for the service as billed when it is reduced.

36.6 - Medicare is paying this claim, this time only, because it appears that neither you nor the provider knew that the service(s) would be denied. Future services of this type provided to you will be your responsibility.

50.37 - Deductible/Coinsurance

(Rev. 1, 10-01-03)

Print the following messages in the "Notes" section as appropriate.

37.1 - This approved amount has been applied toward your deductible. (NOTE: Mandated message - This message should print on each service line with the total approved amount applied to the deductible.)

37.2 - ($_____) of this approved amount has been applied toward your deductible. (NOTE: Mandated message - This message should print on each service line with a portion of the approved amount applied to the deductible.)

37.3 - ($_____) was applied to your inpatient deductible. (NOTE: Mandated message - This message should print on all Part A line items with all, or a portion of the approved amount applied to the inpatient deductible.)

37.4 - ($_____) was applied to your inpatient coinsurance.

37.5 - ($_____) was applied to your skilled nursing facility coinsurance.

37.6 - ($_____) was applied to your blood deductible.

37.7 - Part B cash deductible does not apply to these services.

37.8 - Coinsurance amount includes outpatient mental health treatment limitation.

Print the following messages in the "Deductible Information" Section as appropriate. Print a message for each different type of deductible situation displayed on the MSN. Do not print more than one type of deductible message for each year represented on the MSN. Do not print both 37.9 and 37.11 on the same MSN.

37.9 - You have now met ($_____) of your ($_____) Part B deductible for (year).

37.10 - You have now met ($_____) of your ($_____) Part A deductible for this benefit period.

37.11 - You have met the Part B deductible for (year).

37.12 - You have met the Part A deductible for this benefit period.

37.13 - You have met the blood deductible for (year).

37.14 - You have met ($_____) pint(s) of your blood deductible for (year).

50.38 - General Information Section

(Rev. 1, 10-01-03)

PM AB-02-106

38.3 - If you change your address, please contact (contractor name) by calling (contractor phone) and the Social Security Administration by calling 1-800-772-1213.

38.4 - You are at high risk for complications from the flu and it is very important that you get vaccinated. Please contact your health care provider for the flu vaccine.

38.5 - If you have not received your flu vaccine it is not too late. Please contact your health care provider about getting the vaccine.

38.6 - January is cervical cancer prevention month

38.7 - The Pap test is the most effective way to screen for cervical cancer.

38.8 - Medicare helps pay for screening Pap tests once every two years.

38.9 - Colorectal cancer is the second leading cancer killer in the United States. However, screening tests can find polyps before they become cancerous. They can also find cancer early when treatment works best. Medicare helps pay for screening tests. Talk to your doctor about the screening options that are right for you.

38.10 - Compare the services you receive with those that appear on your Medicare Summary Notice. If you have questions, call your doctor or provider. If you feel further investigation is needed due to possible fraud or abuse, call the phone number in the Customer Service Information Box.

50.41 - Home Health Messages

(Rev. 1, 10-01-03)

41.1 - Medicare will only pay for this service when it is provided in addition to other services.

41.2 - This service must be performed by a nurse with the required psychiatric nurse credentials.

41.3 - The medical information did not support the need for continued services.

41.4 - This item is not considered by Medicare to be appropriate for home use.

41.5 - Medicare does not pay for comfort or convenience items.

41.6 - This item was not furnished under a plan of care established by your physician.

41.7 - This item is not considered by Medicare to be a prosthetic and/or orthotic device.

41.8 - Based on the information provided, your illness or injury did not prevent you from leaving your home unaided.

41.9 - Services exceeded those ordered by your physician.

41.10 - Patients eligible to receive home health benefits from another government agency are not eligible to receive Medicare benefits for the same service.

41.11 - Doctors orders were incomplete.

41.12 - The provider has billed in error for items/services according to the medical record.

41.13 - The provider has billed for services/items not documented in your record.

41.14 - This service/item was billed incorrectly.

41.15 - The information shows that you can do your own personal care.

41.16 - To receive Medicare payment, you must have a signed doctor's order before you receive the services.

50.42 - Religious Nonmedical Health Care Institutions

(Rev. 1, 10-01-03)

PM AB-00-30

42.1 - You received medical care at a facility other than a religious nonmedical health care institution but that care did not revoke your election to receive benefits for religious nonmedical health care.

42.2 - Since you received medical care at a facility other than a religious nonmedical health care institution, benefits for religious nonmedical health care services has been revoked for these services unless you file a new election.

42.3 - This service is not covered since you did not elect to receive religious nonmedical health care services instead of regular Medicare services.

42.4 - This service is not covered because you received medical health care services which revoked your election to religious nonmedical health care services.

42.5 - This service is not covered because you requested in writing that your election to religious nonmedical health care services be revoked.

60 - Add-On Messages

(Rev. 1, 10-01-03)

9.3 - Please ask your provider to submit a new complete claim to us. (NOTE: Add-on to other messages as appropriate.)

9.7 - We have asked your provider to resubmit the claim with the missing or correct information. (NOTE: Add-on to other messages as appropriate.)

15.16 - Your claim was reviewed by our Medicare staff. (NOTE: Add-on to other messages as appropriate.)

15.17 - We have approved this service at a reduced level. (NOTE: Add-on to other messages as appropriate.)

16.34 - You should not be billed for this item or service. You do not have to pay this amount. (Add-on to other messages, or use individually as appropriate.)

16.35 - You do not have to pay this amount. (NOTE: Add-on to other messages as appropriate.)

16.36 - If you have already paid it, you are entitled to a refund from this provider. (NOTE: Add-on to other messages as appropriate.)

16.37 - Please see the back of this notice. (NOTE: Add-on to other messages as you feel appropriate.)

16.45 - You cannot be billed separately for this item or service. You do not have to pay this amount.

25.2 - You can be billed only 20% of the charges that would have been approved. (NOTE: Add-on to 25.1 for assigned claims.)

29.26 - The primary payer is_____. (NOTE: Add-on to other messages as appropriate.)

35.7 - Please do not submit this notice to them (add-on to other messages as appropriate).

29.31 - Resubmit this claim with the missing or correct information.

70 - Mandated Messages

(Rev. 1, 10-01-03)

14.7 - This service is paid at 100% of the Medicare approved amount. (NOTE: Mandated message - This message must appear on all service lines paid at 100% of the Medicare approved amount.)

16.11 - Payment was reduced for late filing. You cannot be billed for the reduction. (NOTE: Mandated message - This message must print on all service lines subject to the 10% reduction.)

16.12 - Outpatient mental health services are paid at 50% of the approved charges. (NOTE: Mandated message - This message must print on all service lines subject to the outpatient psychiatric reduction.)

16.33 - Your payment includes interest because Medicare exceeded processing time limits. (NOTE: Mandated message - This message must print claim level if interest is added into the beneficiary payment amount for unassigned or split pay claims.)

20.4 - (__) of the Benefit Days Used were charged to your Lifetime Reserve Day benefit. (NOTE: Mandated message - This message must be printed claim level when all or a portion of the Benefit Days Used are charged to the Lifetime Reserve Day benefit.)

22.1 - Your claim was separated for processing. The remaining services may appear on a separate notice. (NOTE: Mandated message - This message must print claim level on all split claims, including the original and replicate claim.)

29.14 - Medicare's secondary payment is ($_____). This is the difference between the primary insurer's approved amount of ($_____) and the primary insurer's paid amount of ($_____). (NOTE: Mandated message - This message should print service level when a Medicare secondary payment is made and the primary insurer's approved amount is higher than Medicare's approved amount. Do not print when the claim paid amount is equal to the amount Medicare would pay if services were not covered by a third party insurer. This message should print claim level for MSNs containing claims or adjustments having the Medicare secondary payment calculated at the claim level.)

29.15 - Medicare's secondary payment is ($_____). This is the difference between Medicare's approved amount of ($_____) and the primary insurer's paid amount of ($_____). (NOTE: Mandated message - This message should print service level when a Medicare secondary payment is made and Medicare's approved amount is higher than the primary insurer's approved amount. Do not print when the claim paid amount is equal to the amount Medicare would pay if services were not covered by a third party payer. This message should print claim level for MSNs containing claims or adjustments having the Medicare secondary payment calculated at the claim level.)

29.16 - Your primary insurer approved and paid ($_____) on this claim. Therefore, no secondary payment will be made by Medicare. (NOTE: Mandated message - This message should print service level when the primary insurer's approved amount is higher than Medicare's approved amount and the primary payment is equal to the approved amount. Do not print on denied service lines. This message should print claim level for MSNs containing claims or adjustments having the Medicare secondary payment calculated at the claim level. Print either "claim" or "service" in the message as applicable. Do not print "claim/service.")

29.17 - Your provider agreed to accept ($_____) as payment in full on this (claim/service). Your primary insurer has already paid ($_____) so Medicare's payment is the difference between the two amounts. (NOTE: Mandated message - This message should print service level when the provider is obligated to accept less than the Medicare approved amount. Print the message at the claim level for MSNs containing claims or adjustments having the Medicare secondary payment calculated at the claim level. Print either "claim" or "service" in the message as applicable. Do not print "claim/service.")

29.18 - The amount listed in the "You May Be Billed" column assumes that your primary insurer paid the provider. If your primary insurer paid you, then you are responsible to pay the provider the amount your primary insurer paid to you plus the amount in the "You May Be Billed" column. (NOTE: Mandated message - This message should print on all assigned MSP service lines when Medicare secondary payment was made. Print message on assigned service lines for full recoveries. Do not print on denied service lines.)

29.19 - The amount listed in the "You May Be Billed" column assumes that your primary insurer paid you. If your primary insurer paid the provider, then you only need to pay the provider the difference between the amount charged and the amount the primary insurer paid. (NOTE: Mandated message - This message should print on all unassigned MSP service lines when Medicare secondary payment was made. Print message on unassigned service lines for full recoveries. Do not print on denied service lines. Do not print when conditions in 29.20 or 29.22 are met.)

29.20 - The amount listed in the "You May Be Billed" column assumes that your primary insurer paid you. If your primary insurer paid the provider, then you only need to pay the provider the difference between the amounts the provider agreed to accept and the amount the primary insurer paid. (NOTE: This message should print on all unassigned MSP service lines when the provider is obligated to accept less than the Medicare approved amount. Do not print on denied service lines.)

29.21 - The amount listed in the "You May Be Billed" column assumes that your primary insurer made no payment for this service. If your primary insurer did make payment for this service, the amount you may be billed is the difference between the amount charged and the primary insurer's payment. (NOTE: Mandated message - This message should print on all Medicare disallowed services for which the beneficiary is liable and the service has been submitted on a claim indicating there has been a primary insurer payment made.)

29.22 - The amount listed in the "You May Be Billed" column assumes that your primary insurer paid you. If your primary insurer paid the provider, then you only need to pay the provider the difference between the amount the provider can legally charge and the amount the primary insurer paid. See note (__) for the legal charge limit. (NOTE: This message should print on all unassigned MSP service lines when a Medicare secondary payment is made and the provider has exceeded the limiting charge.)

29.32 - Medicare's secondary payment is ($_____). This is the difference between Medicare's limiting charge amount of ($_____) and the primary insurer's paid amount of ($_____). (NOTE: Mandated message - This message should print service level when the Medicare secondary payment is the difference between the limiting charge amount and the primary insurer's paid amount.)

30.3 - Your doctor did not accept assignment for this service. Under Federal law, your doctor cannot charge more than ($_____). If you have already paid more than this amount, you are entitled to a refund from the provider. (NOTE: This message should print on all assigned service lines for which the billed amount exceeds the Medicare limiting charge. Do not print when the amount the limiting charge is exceeded is less than any threshold established by CMS.)

34.3 - After applying Medicare guidelines and the amount you paid to the provider at the time the services were rendered, our records indicate you are entitled to a refund. Please contact your provider. (NOTE: Mandated message - This message should print on assigned claims with a split payment to the beneficiary under $1.00.)

31.11 - The previous notice we sent stated that your doctor could not charge more than ($_____). This additional payment allows your doctor to bill you the full amount charged. (NOTE: Mandated message - This message should print claim level, as appropriate, when limiting charge applies.)

31.12 - The previous notice we sent stated the amount you could be charged for this service. This additional payment changed that amount. Your doctor cannot charge you more than ($_____). (NOTE: Mandated message - This message should print claim level, as appropriate, when limiting charge applies.)

31.13 - The Medicare paid amount has been reduced by ($_____) previously paid for this claim. (NOTE: Mandated message - This message should print claim level on all adjustments for which a partial payment was previously made.)

32.1 - ($_____) of this payment has been withheld to recover a previous overpayment. (NOTE: Mandated message - This message should print claim level when the beneficiary check amount is reduced to recover a previous overpayment. Fill in the blank with the amount withheld on the claim at issue.)

34.1 - Of the total ($_____) paid on this claim, we are paying you ($_____) because you paid your provider more than your 20% coinsurance on Medicare approved services. The remaining ($_____) was paid to the provider. (NOTE: Mandated message - This message should print claim level on all assigned split pay claims.)

34.2 - The amount in the "You May Be Billed" column has been reduced by the amount you paid the provider at the time the services were rendered. (NOTE: Mandated message - This message should print claim level on all assigned claims with a beneficiary paid amount that does not exceed coinsurance and deductible and for all unassigned claims submitted with a beneficiary paid amount.)

34.3 - After applying Medicare guidelines and the amount you paid to the provider at the time the services were rendered, our records indicate you are entitled to a refund. Please contact your provider. (NOTE: Mandated message - This message should print claim level on assigned claims with a split payment to the beneficiary under $1.00.)

34.8 - The amount you paid the provider for this claim was more than the required payment. You should be receiving a refund of ($_____) from your provider, which is the difference between what you paid and what you should have paid. (NOTE: Mandated message - This message should print claim level on assigned claims with a split payment to the beneficiary under $1.00.)

37.1 - This approved amount has been applied toward your deductible. (NOTE: Mandated message - This message should print on each service line with the total approved amount applied to the deductible.)

37.2 - ($_____) of this approved amount has been applied toward your deductible. (NOTE: Mandated message - This messages should print on each service line with a portion of the approved amount applied to the deductible.)

37.3 - ($_____) was applied to your inpatient deductible. (NOTE: Mandated message - This message should print on all Part A line items with all, or a portion of the approved amount applied to the inpatient deductible.)

Print the following messages in the "Deductible Information Section" as appropriate. Print all messages that apply. There must be at least one message printed in the deductible section for all MSNs.

37.9 - You have now met ($_____) of your ($_____) Part B deductible for (year).

37.10 - You have now met ($_____) of your ($_____) Part A deductible for this benefit period.

37.11 - You have met the Part B deductible for (year).

37.12 - You have met the Part A deductible for this benefit period.

37.13 - You have met the blood deductible for (year).

37.14 - You have met ($_____) pints of your blood deductible.

80 - Demonstration Project

(Rev. 1, 10-01-03)

AB-01-30, AB-01-97, AB-01-149, B-00-48

60.1 - In partnership with physicians in your area, _____ is participating in a Medicare demonstration project that uses a simplified payment method to combine all hospital and physician care related to your hospital service.

60.2 - The total Medicare approved amount for your hospital service is ($_____). ($_____) is the Part A Medicare amount for hospital services and ($_____) is the Part B Medicare amount for physician services (of which Medicare pays 80 percent). You are responsible for any deductible and coinsurance amounts represented.

60.3 - Medicare has paid ($_____) for hospital and physician services. Your Part A deductible is ($_____). Your Part A coinsurance is ($_____) Your Part B coinsurance is ($_____). Your Part A blood deductible is ($_____).

60.4 - This claim is being processed under a demonstration project.

60.5 - This claim is being processed under a demonstration project. If you would like more information about this project, please contact 1-888-289-0710.

60.6 - A claim has been submitted on your behalf indicating that you are participating in the Medicare Coordinated Care Demonstration project**.** However, our records indicate that you are not currently enrolled or your enrollment has not yet been approved for the demonstration.

60.7 - A claim has been submitted on your behalf indicating that you are participating in the Medicare Coordinated Care Demonstration project**.** However, our records indicate that either you have terminated your election to participate in the demonstration project or the dates of service are outside the demonstration participation dates.

60.8 - The approved amount is based on the maximum allowance for this item under the DMEPOS Competitive Bidding Demonstration.

60.9 - Our records indicate that this patient began using this service(s) prior to the current round of the DMEPOS Competitive Bidding Demonstration. Therefore, the approved amount is based on the allowance in effect prior to this round of bidding for this item.

60.10 - Even though this service is being paid in accordance with the rules and guidelines under the Competitive Bidding Demonstration, future claims may be denied when this item is provided to this patient by a non-demonstration supplier. If you would like more information regarding this project, you may contact 1-888-289-0710.

60.11 - This payment is being retracted because the services provided are covered under a demonstration project in which the hospital receives payment for all physician and

hospital services related to this admission. The provider should seek reimbursement directly from the hospital where the care was provided. Any deductible or coinsurance paid by you or your supplemental insurer for these services should be returned by the provider.

90 - Spanish Messages

(Rev. 1, 10-01-03)

A3-3726.14A, B3-7014, A-99-48, AB-02-106, B-02-047, AB-02-155, B-02-029

NOTE: These messages generally but not always correspond numerically to the English messages.

90.1 - Ambulancia

(Rev. 1, 10-01-03)

1.1 - El pago por la transportación está aprobado sólo hasta la facilidad más cercana que pueda proveer el cuidado necesario.

1.2 - El pago fue denegado porque la compañía de ambulancia no tiene la aprobación de Medicare.

1.3 - Servicio de ambulancia a una funeraria no está cubierto.

1.4 - Transportación en un vehículo que no sea una ambulancia no está cubierto por Medicare.

1.5 - Transportación a una facilidad para estar cerca de su hogar o de un familiar no está cubierto.

1.6 - Este servicio está incluido en el pago total por la transportación en ambulancia.

1.7 - Servicios de ambulancia a la oficina o desde la oficina del médico no están cubiertos.

1.8 - Este servicio fue denegado porque usted rehusó ser transportado(a).

1.9 - Pagos por servicios de ambulancia no incluyen millaje cuando usted no estaba en la ambulancia.

1.10 - Servicio de ambulancia aérea no está cubierto, porque usted no fue transportado(a) al aereopuerto en ambulancia.

1.11 - La información suministrada no justifica la necesidad de una ambulancia aérea. La cantidad aprobada es basada en ambulancia terrestre.

90.2 - Sangre

(Rev. 1, 10-01-03)

2.1 - Las primeras tres pintas de sangre usadas cada año no son cubiertas por Medicare.

2.2 - Los cargos por sangre reemplazada no son cubiertos por Medicare.

90.3 - Quiropráctico

(Rev. 1, 10-01-03)

3.1 - Estos servicios son cubiertos solamente cuando radiografías recientes justifícan la necesidad del servicio.

90.4 - Deficiencia Renal Terminal

(Rev. 1, 10-01-03)

4.1 - Este cargo representa más de la cantidad que Medicare paga por terapia de mantenimiento de una enfermedad renal.

4.2 - Este servicio es cubierto hasta (intercale número apropiado) meses después del transplante y estadía en el hospital.

4.3 - Recetas para drogas immunosupresivas son limitadas a una provisión para 30 días.

4.4 - Solamente un suplidor por mes puede ser pagado por estos suministros o servicios.

4.5 - Medicare paga al hospital por la parte profesional de este cargo.

4.6 - Este servicio fue reducido por el número de días que usted no estaba en el lugar de tratamiento acostumbrado.

4.7 - Pago por todo equipo y provisiones se hace a través de su centro de diálisis. Ellos envían la cuenta a Medicare por estos servicios.

4.8 - Este servicio no se pagó debido a que usted no eligió una opción para su equipo y suministros de diálisis.

4.9 - Este cargo se redujo o se denegó porque el pago máximo mensual permitido para este equipo de diálisis para el hogar y provisiones fue alcanzado.

4.10 - No más de ($_____) puede ser pagado mensualmente por estos suministros.

4.11 - La cantidad que aparece en la columna “Podría Ser Facturado” está basada en la cantidad aprobada por Medicare. Usted no es responsable por la diferencia entre la cantidad facturada y la cantidad aprobada.

90.5 - Número/Nombre/Inscripción

(Rev. 1, 10-01-03)

5.1 - Nuestros archivos indican que usted no está cubierto(a) bajo el número de Medicare en esta notificación. Si usted no está de acuerdo, comuníquese con la oficina del Seguro Social.

5.2 - El nombre o número de Medicare es incorrecto o fue omitido. Por favor, revise su tarjeta de Medicare. Si la información en esta notificación es diferente a la de su tarjeta, comuníquese con el proveedor del servicio.

5.3 - Nuestros archivos indican que la fecha de fallecimiento fue antes de la fecha del servicio.

5.4 - Si usted cambia el cheque adjunto, usted está legalmente obligado a pagar por estos servicios. Si usted no desea asumir esta obligación, favor de devolvernos este cheque.

5.5 - Nuestros archivos indican que usted no tenía la Parte A (B) cuando recibió éstos servicios. Si usted no está de acuerdo favor de llamar al número de Servicios al Cliente indicado en esta notificación.

5.6 - El nombre o número de Medicare es incorrecto o fue omitido. Pídale a su proveedor de servicios que use el nombre y número indicados en esta notificación para futuras reclamaciones.

90.6 - Drogas

(Rev. 1, 10-01-03)

6.1 - Este medicamento es cubierto solamente cuando Medicare paga por el transplante.

6.2 - Medicamentos que no están específicamente clasificados como efectivos por la Administración de Alimentos y Drogas no son cubiertos.

6.3 - No se puede pagar por medicamentos orales que no tengan los mismos ingredientes activos como tienen aquellos que sean administrados por inyección.

6.4 - Medicare no paga por un medicamento anti-emético oral, que no es administrado antes, en, o dentro de un periodo de 48 horas, después de la administración de un medicamento de quimioterapia cubierto por Medicare.

6.5 - Medicare no puede pagar por esta inyección porque uno o más requisitos para la cubierta no fueron cumplidos.

90.7 - Duplicados

(Rev. 1, 10-01-03)

B-02-047

7.1 - Este es un duplicado de un cargo previamente sometido.

7.2 - Este es un duplicado de una reclamación procesada por otro contratísta de Medicare. Usted debe recibir un Resumen de Medicare de ellos.

7.3 - Este servicio/articulo es un duplicado de otro servicio procesado previamente. No tiene derechos de apelación por la denegación de este servicio, excepto si cuestiona que este servicio es un duplicado. Haga caso omiso a la información sobre apelaciones en esta notificátión, en relación a sus derechos de apelación, a menos que esté apelando si el servicio fue duplicado.

90.8 - Equipo Médico Duradero

(Rev. 1, 10-01-03)

B-01-13, B-02-029

8.1 - Su suplidor es responsable por el servicio y reparación de su equipo alquilado.

8.2 - Para usted poder recibir un pago de Medicare, debió obtener una receta médica antes de alquilar o comprar este equipo.

8.3 - Este equipo no está cubierto ya que su uso primario no es por razones médicas.

8.4 - Medicare no paga por equipo que es igual o similar al equipo que usted está usando actualmente.

8.5 - Equipo alquilado que no es necesario ni usado, no está cubierto.

8.6 - Hemos hecho un pago parcial porque la cantidad permitida de compra ha sido alcanzada. No se pagarán gastos de alquiler adicionales.

8.7 - Este equipo está cubierto solamente cuando es alquilado.

8.8 - Este equipo está cubierto solamente cuando es comprado.

8.9 - El pago se redujo por la cantidad ya pagada por el alquiler de este equipo.

8.10 - El pago está incluido en la cantidad aprobada por otro equipo.

8.11 - La cantidad de compra ha sido alcanzada. Si usted continúa alquilando esta pieza de equipo, los cargos por alquiler son su responsabilidad.

8.12 - La cantidad aprobada está basada en la cantidad de oxígeno recetada por el médico.

8.13 - Pagos mensuales por alquiler pueden hacerse hasta 15 meses desde el primer mes de alquiler o hasta que el equipo no sea necesario, lo que ocurra primero.

8.14 - Su suplidor debe proveer y dar servicio al equipo por el tiempo que sea necesario. Medicare pagará por el mantenimiento y/o servicio por cada periodo de 6 meses después de finalizar el pago 15 del alquiler.

8.15 - Mantenimiento y/o servicio de este artículo no está cubierto hasta 6 meses después de finalizar el pago 15 de alquiler.

8.16 - La cantidad mensual permitida incluye el pago por oxígeno y sus artículos.

8.17 - El pago por este artículo está incluido en la cantidad del pago mensual de alquiler.

8.18 - Este pago se denegó porque el suplidor no obtuvo la orden por escrito del médico antes de entregar el artículo.

8.19 - Los impuestos de venta fueron incluidos en la cantidad aprobada por este artículo.

8.20 - Medicare no paga por este equipo o artículo.

8.21 - Este artículo no puede ser pagado sin obtener un certificado de necesidad médica nuevo, revisado o renovado.

8.22 - No se pueden hacer más pagos porque el costo de las reparaciones ha igualado el precio de compra de este artículo.

8.23 - No se puede hacer el pago debido a que el artículo ha llegado al límite de 15 meses. Pagos separados se pueden hacer por mantenimiento y reparaciones cada 6 meses.

8.24 - La reclamación no demuestra que usted es dueño o esté comprando equipo que necesite estas piezas o suministros.

8.25 - El pago no se hará hasta que usted le diga al suplidor si usted desea alquilar o comprar el equipo.

8.26 - Empezando el cuarto mes de alquiler los pagos se reducen en 25%.

8.27 - Los pagos de alquiler se limitan a 13 pagos porque usted decidió comprar el equipo.

8.28 - El mantenimiento, servicio, reemplazo o reparación de este artículo no está cubierto.

8.29 - El pago se autoriza para el mecanismo que levanta la silla, no para la silla completa.

8.30 - Este artículo no está cubierto debido que el médico no llenó el certificado de necesidad médica.

8.31 - El pago fue denegado porque exámenes de gas en la sangre no pueden ser administrados por un suplidor de equipo médico duradero.

8.32 - Este artículo se puede alquilar por 2 meses solamente. Debe ser comprado si lo necesita por más tiempo.

8.33 - Este es el penúltimo pago por este artículo.

8.34 - Este es el último pago por este artículo.

8.35 - Este artículo no está cubierto cuando el oxígeno no está en uso.

8.36 - El pago se denegó debido a que el certificado de necesidad médica en nuestros archivos no estaba en efecto en la fecha de este servicio.

8.37 - Un formulario de re-certificación fue enviado a su médico.

8.38 - Este artículo debe ser alquilado por 2 meses antes de comprarlo.

8.39 - Este es el décimo mes de pago por alquiler. Su suplidor le debe ofrecer la opción de cambiar el acuerdo de alquiler a un acuerdo de compra.

8.40 - Hemos pagado anteriormente por la compra de este artículo.

8.41 - El pago por la cantidad de oxígeno suplido ha sido reducido o denegado debido a que el límite mensual ha sido alcanzado.

8.42 - Equipo listo para usar en caso de necesidad no está cubierto.

8.43 - El pago fue denegado debido que el equipo no puede proveer los litros por minuto recetados por su médico.

8.44 - El pago fue basado en un artículo corriente debido que la información recibida no demostró la necesidad para usar uno de lujo o más costoso.

8.45 - Los pagos para las sillas de ruedas eléctricas son permitidos si la decisión de compra fue hecha en el primer o décimo mes de alquiler.

8.46 - El pago fue incluido en otro artículo o servicio proporcionado al mismo tiempo.

8.47 - Medicare no pagará por suministros o accesorios usados con equipo que no está cubierto.

8.48 - El pago de este medicamento ha sido denegado porque la necesidad de este equipo no ha sido demostrada.

8.49 - El pago ha sido reducido porque parte de este artículo fue pagado en otra reclamación.

8.50 - Medicare no puede pagar por esta medicina o por el equipo debido a que nuestros expedientes no muestran que su suplidor está autorizado para distribuir medicinas, y, por lo tanto, no puede asegurar la seguridad y efectividad de la medicina o del equipo. En el futuro, si usted desea que Medicare pague por esta medicina, usted debe obtener la medicina por una farmacia autorizada.

8.51 - Usted no es responsable de ningún cargo adicional como resultado de obtener un artículo de lujo o más costoso.

8.52 - Usted firmó una Notificación Previa al Beneficiario. Usted es responsable de la diferencia entre el costo del artículo de lujo o más costoso y el pago de Medicare.

8-53 - Este artículo/servicio fue denegado porque la información del artículo/servicio de lujo o más costoso era inválida.

90.9 - Falta De Información Sometida

(Rev. 1, 10-01-03)

9.1 - La información solicitada no fue recibida.

9.2 - Este artículo o servicio fue denegado porque la información requerida para hacer el pago fue omitida.

9.3 - Por favor solicite a su proveedor que nos envíe una nueva reclamación completa.

9.4 - Este servicio fue denegado debido a que la información requerida para hacer el pago fue incorrecta.

9.5 - Nuestros archivos indican que su médico no ordenó estos suministros o cantidad de suministros.

9.6 - Favor de pedirle a su proveedor que someta esta reclamación con la lista detallada de los cargos o servicios.

9.7 - Le hemos pedido a su proveedor que envíe la reclamación con la información omitida o incorrecta.

9.8 - Le hemos pedido al hospital que nos provea información adicional, por ahora, usted no deberá recibir una factura.

9.9 - Este servicio no está cubierto a menos de que el suplidor tramite una reclamación de medio electrónico (EMC, por sus siglas en inglés).

90.10 - Cuidado De Los Pies

(Rev. 1, 10-01-03)

10.1 - Zapatos están cubiertos solamente como parte de una abrazadera de pierna.

90.11 - Reclamaciones Transferidas

(Rev. 1, 10-01-03)

B3-3110

11.1 - Su reclamación fue enviada al contratísta de Medicare apropiado para ser procesada. Usted recibirá una notificación de ellos.

(NOTE: Use for carriers, intermediaries, RRB, United Mine Workers.)

11.2 - Esta información se está enviando a Medicaid. Ellos la revisarán para ver si beneficios adicionales pueden ser pagados.

11.3 - Nuestros archivos indican que usted está inscrito en una Organización para el Mantenimiento de la Salud. Su proveedor debe facturarle este servicio a ellos.

11.4 - Nuestros archivos indican que usted está registrado en una Organización para el Mantenimiento de la Salud. Su reclamación fue transferida a ellos para ser procesada.

11.5 - Esta reclamación debe ser sometida a (agencia de seguros de Medicare Parte B, agencia regional de seguros para equipo médico duradero o agencia de Medicaid).

11.6 - Le hemos pedido a su proveedor que resometa esta reclamación a la agencia de seguros de Medicare Parte B (intermediario) correspondiente. Dicha agencia de seguros de Medicare Parte B es (nombre y dirección de la agencia de seguros de Medicare Parte B, intermediario, o agencia regional de seguros para de equipo médico duradero, etc.).

11.7 - Esta reclamación/servicio no se paga bajo nuestra juridicción de reclamaciones. Le hemos notificado a su proveedor que debe enviar la reclamación/servicio a la agencia de seguros de Medicare Parte B apropiada para ser procesada.

11.9 - Esta reclamación/servicio no se paga bajo nuestra juridicción de reclamaciones. Le hemos notificado a su proveedor que debe enviar la reclamación por estos servicios a la Junta de Retiro Ferroviario (RRB, por sus siglas en inglés), agencia de seguros de Medicare Parte B.

90.12 - Audífonos

(Rev. 1, 10-01-03)

12.1 - Audífonos no son cubiertos.

90.13 - Instalación de Enferemería Especializada

(Rev. 1, 10-01-03)

AB-01-169, B-00-67

13.1 - No se demostraron fechas aprobadas de estadía en el hospital para una estadía en esta instalación de enfermería especializada.

13.2 - Los beneficios de una instalación de enfermería especializada son obtenibles solamente después de una estadía en el hospital de por lo menos 3 días.

13.3 - La información proporcionada no confirma la necesidad de una estadía en una instalación de enfermería especializada.

13.4 - La información proporcionada no confirma la necesidad de continuar los servicios de cuidado de una instalación de enfermería especializada.

13.5 - Usted no fue ingresado en una instalación de enfermería especializada dentro de los 30 días después de ser dado de alta en el hospital.

13.6 - Los beneficios de cuidado primario en una instalación de enfermería especializada rural son obtenibles después de una estadía de hospital de por lo menos 2 días.

13.7 - Normalmente, servicios de cuidado de salud no están cubiertos cuando son proporcionados en una cama que no está certificada por Medicare. Sin embargo, como usted recibió servicios de cuidado de salud que sí estaban cubiertos, decidimos que no tiene que pagarle a la institución nada más que el seguro complementario y los artículos y servicios que Medicare no cubre.

13.8 - La instalación de enfermería especializada (SNF, por sus siglas en inglés) debe archivar una reclamación para beneficios de Medicare porque usted estaba hospitalizado.

13.9 - Medicare Parte B no paga por este artículo o servicio ya que nuestros expedientes indican que usted estaba en una instalación de enfermería especializada (SNF, por sus siglas en inglés) en esta fecha. Su proveedor debe cobrarle este servicio a la instalación de enfermería especializada o a el intermediario fiscal.

90.14 - Laboratorios

(Rev. 1, 10-01-03)

14.1 - El laboratorio no está aprobado para este tipo de pruebas.

14.2 - Medicare aprobó _____ por _____ específico porque puede ser hecho como parte de un grupo completo de pruebas.

14.3 - Servicios o artículos que no son aprobados por la Administración de Drogas y Alimentos no están cubiertos.

14.4 - El pago fue denegado debido a que la reclamación no indicaba quién realizó las pruebas y/o la cantidad cobrada.

14.5 - El pago fue denegado debido a que la reclamación no indicaba si las pruebas fueron compradas por el médico o si el médico realizó las pruebas.

14.6 - Estas pruebas deben ser facturadas por el laboratorio que hizo el trabajo.

14.7 - Este servicio es pagado al 100% de la cantidad aprobada por Medicare.

14.8 - No se puede pagar debido a que el médico tiene relaciones financieras con el laboratorio.

14.9 - Medicare no puede pagar por este servicio debido al diagnóstico indicado en la reclamación.

14.10 - Medicare no permite un pago por separado para la lectura del electro-cardiograma.

14.11 - Gastos de viaje se pagan solamente cuando se factura por la colección de una muestra cubierta.

14.12 - Medicare no paga por transportación si una radiografía o un electro-cardiograma no fue realizado.

14.13 - El laboratorio no tenía la aprobación para esta prueba en la fecha que fue realizada.

90.15 - Necesidad Médica

(Rev. 227, Issued 07-09-04) (Effective: February 3, 2004/Implementation: August 9, 2004)

15.1 - La información proporcionada no confirma la necesidad de esta cantidad de servicios o artículos.

15.2 - La información proporcionada no confirma la necesidad para este equipo.

15.3 - La información proporcionada no confirma la necesidad para las características especiales de este equipo.

15.4 - La información proporcionada no confirma la necesidad para este servicio o artículo.

15.5 - La información proporcionada no confirma la necesidad por servicios similares por más de un médico durante el mismo periodo.

15.6 - La información proporcionada no confirma la necesidad de estos servicios o artículos en este periodo de tiempo.

15.7 - La información proporcionada no confirma la necesidad de más de una visita al día.

15.8 - La información proporcionada no confirma el nível de servicios según indicado en la reclamación.

15.9 - La Organización para el Mejoramiento de la Calidad no aprobó este servicio.

15.10 - Medicare no paga por más de un asistente de cirujano para este procedimiento.

15.11 - Medicare no paga por el asistente del cirujano por este procedimiento/cirugía.

15.12 - Medicare no paga por dos cirujanos para este procedimiento.

15.13 - Medicare no paga por un equipo de cirujanos para este procedimiento.

15.14 - Medicare no paga por acupuntura.

15.15 - El pago se redujo debido a que la información recibida no confirma la necesidad para este artículo como fue facturado.

15.16 - Su reclamación fue revisada por nuestro personal médico.

15.17 - Hemos aprobado este servicio con un índice de pago reducido.

15.18 - Medicare no cubre este servicio en su casa.

15.19- Una Política Local de Revisión Médica (LMRP, por sus siglas en inglés) o una Determinación de Cobertura Local (LCD, por sus siglas en inglés) fue utilizada cuando se tomó esta decisión. La Política Local de Revisión Médica y la Determinación de Cobertura Local proveen una guía que ayuda a determinar si un artículo o servicio en particular está cubierto por Medicare. Una copia de esta política está disponible en su intermediario o su empresa de seguros Medicare local al llamar al número que aparece en la sección de Servicios al Cliente en la página uno. Usted puede comparar los datos de su caso con las reglas establecidas en la Política Local de Revisión Médica y en la Determinación de Cobertura Local para ver si obteniendo información adicional de su médico pudiera cambiar nuestra decisión

15.20 - Las siguientes políticas [añadir los #s de LMRP/LCD, por sus siglas en inglés y los #s de NCD, por sus siglas en inglés] fueron utilizadas cuando se tomó esta decisión.

90.16 - Miscelaneo

(Rev. 1, 10-01-03)

B-01-10, AB-01-79, A-01-69, A-01-132, B-01-2, AB-01-155

16.1 - Este servicio no puede ser aprobado debido que la fecha en la reclamación indica que fue facturado antes del servicio.

16.2 - Este servicio no se puede pagar cuando es suministrado en esta sitio/facilidad.

16.3 - La reclamación no muestra que el servicio o artículo fue recetado por su médico.

16.4 - Este servicio requiere aprobación de la Organización para el Mejoramiento de la Calidad.

16.5 - Este servicio no se aprobará sin el plan de tratamiento por el terapísta ocupacional o físico.

16.6 - Este artículo o servicio no se pagará a menos de que el proveedor acepte asignación.

16.7 - Su proveedor debe completar y someter su reclamación.

16.8 - El pago fue incluido en otro servicio recibido el mismo día.

16.9 - Este pago ha sido reducido por la cantidad previamente pagado por un procedimiento relacionado.

16.10 - Medicare no paga por este artículo o servicio.

16.11 - El pago fue reducido por enviar la reclamación tarde. A usted no le pueden cobrar esta reducción.

16.12 - Servicios de salud mental como paciente externo se pagan al 50% del costo aprobado.

16.13 - El/los código(s) que usó su proveedor no es/son válido(s) en la fecha de servicio facturada.

16.14 - El cheque adjunto reemplaza su cheque (#_____), fechado (_____.)

16.15 - El cheque adjunto reemplaza su cheque anterior.

16.16 - De acuerdo a su solicitud, éste es un duplicado del Resumen de Medicare.

16.17 - Medicare no paga por este servicio cuando no es proporcionado conjuntamente con una alimentación parenteral total.

16.18 - Servicio proporcionado antes de la fecha autorizada para comenzar una terapia de alimentación parenteral/nasogástrica no está cubierto.

16.19 - La cantidad aprobada para esta alimentación parenteral/nasogástrica está basada en un nivel de más bajo de cuidado por la naturaleza del diagnóstico indicado.

16.20 - El pago aprobado por calorías-gramos es la cantidad mayor que Medicare aprueba según establecido en la prueba diagnóstica.

16.21 - El código de procedimiento fue cambiado para reflejar los servicios actuales rendidos.

16.22 - Medicare no paga por servicios cuando la cantidad a cobrar no se indica.

16.23 - Este cheque es por la cantidad en exceso que usted pagó para aplicar a un sobrepago anterior.

16.24 - Servicios proporcionados abordo de un barco son cubiertos solamente cuando el barco está registrado en los Estados Unidos y está en aguas territotiales de los Estados Unidos. Además, el servicio debe ser proporcionado por un médico con licencia para practicar en los Estados Unidos.

16.25 - Medicare no paga por tantos servicios o suministros.

16.26 - Medicare no paga por servicios o artículos relacionados con procedimientos que no han sido aprobados ni facturados.

16.27 - Este servicio no está cubierto porque nuestros archivos indican que usted estaba recluído en el hospital.

16.28 - Medicare no paga por servicios o equipo que usted no recibió.

16.29 - El pago fue incluido en otro servicio que usted recibió.

16.30 - Hemos combinado los servicios facturados bajo un solo procedimiento.

16.31 - Es su responsabilidad pagar al médico primario el costo mensual acordado.

16.32 - Medicare no paga este servicio por separado.

16.33 - Su pago incluye interéses debido a que Medicare excedió el tiempo límite para procesar la reclamación.

16.35 - Usted no tiene que pagar esta cantidad.

16.37 - Por favor vea al dorso de esta notificación.

16.38 - No se incurre en cargos por días de ausencia.

16.39 - Solamente un proveedor al mes puede ser pagado por este servicio. Ya se le ha pagado a otro proveedor por este servicio.

16.40 - Solamente un servicio al día por paciente interno es aprobado.

16.41 - El pago se está denegando porque usted rehusó pedir un reembolso bajo sus beneficios de Medicare.

16.42 - La determinación del proveedor de no existir cubierta es correcta.

16.43 - Este servicio no puede ser aprobado sin un plan de tratamiento y supervisión de un médico.

16.44 - Cuidados rutinarios no están cubiertos.

16.45 - Usted no puede ser facturado separadamente por este artículo o servicio. Usted no tiene que pagar esta cantidad.

16.46 - Los límites de pago de Medicare no afectan el derecho de los Indígenas Americanos al servicio gratis prestado en las Instituciones de Salud Indígena.

16.47 - Cuando el deducible es aplicado a servicios psiquiátricos fuera del hospital, a usted le pueden facturar hasta la cantidad aprobada. La columna titulada “Podría Ser Facturado” le indicará la cantidad correcta que usted debe pagar a su proveedor.

16.48 - Medicare no paga por este artículo o servicio para esta afección.

16.49 - Esta reclamación/servicio no está cubierta por que servicios alternativos estaban disponibles, y debieron ser utilizados.

16.50 - El doctor o suplidor no podrá facturar más que la cantidad aprobada por Medicare.

16.51 - Este servicio no se cubre antes del 1 de abril de 2001.

16.52 - Este servicio fue negado debido a que la cobertura para este servicio es proporcionada solamente después de una prueba documentada sin éxito del ejercicio de entrenamiento del músculo pélvico.

16.53 - La cantidad que Medicare pagó al proveedor por esta reclamación es ($_____.)

16.54 - Este servicio no está cubierto antes del 1 de enero de 2002.

90.17 - Servicios Que No Fueron Prestados Por Doctores

(Rev. 1, 10-01-03)

AB-03-057

17.1 - Servicios realizados por una enfermera privada no están cubiertos.

17.2 - Su médico debe facturar por este servicio de anestesia.

17.3 - Este servicio se denegó porque usted no lo recibió bajo la supervisión directa de un médico.

17.4 - Servicios realizados por un audiólogo no son cubiertos, excepto por procedimientos diagnósticos.

17.5 - El patrón de su proveedor debe enviar esta reclamación y estar de acuerdo en aceptar la asignación.

17.6 - Debido a que usted alcanzó su límite anual por este servicio, no se hará un pago completo.

17.7 - Este servicio debe ser realizado por un trabajador social clínico autorizado.

17.8 - El pago fue denegado debido a que usted alcanzó el pago máximo del beneficio.

17.9 - Este servicio es pagado por Medicare (Parte A/Parte B). El proveedor debe enviar la factura al contratista de Medicare correcto.

17.10 - La cantidad aprobada ha sido reducida porque el anestesiólogo dirigió procedimientos médicos concurrentes.

17.11 - Este servicio no se puede pagar según facturado.

17.12 - Este servicio no es cubierto cuando es proporcionado por un terapísta independiente.

17.13 - Coda año, Medicare aprueba una cantidad límite por servicios de terapia física y patología del lenguaje. Anualmente también aprueba otra cantidad límite por servicios de terapia ocupacional cuando son facturados por proveedores, terapistas físicos y ocupacionales, médicos y otros practicantes no médicos. La terapia que es medicamente necesaria y que sobrepasa estas cantidades límites está cubierta cuando se recibe en una unidad de hospital ambulatorio.

17.14 - Los costos por terapia de mantenimiento no están cubiertos.

17.15 - Este servicio no puede ser pagado si no está certificado por su médico cada (___) días.

17.16 - El hospital debe radicar una reclamación por los beneficios de Medicare porque estos servicios fueron prestados en un hospital.

17.18 - En este año (CCYY), ($) han sido deducidos de la cantidad límite de ($) por los beneficios de terapia física ambulatoria y de patología del lenguage hablado.

17.19 - En este año (CCYY), ($) han sido deducidos de la cantidad límite de ($) por los beneficios de terapia ocupacional ambulatoria.90.18 - Cuidado Preventivo

(Rev. 1, 10-01-03)

18.1 - Exámenes rutinarios y servicios relacionados no están cubiertos por Medicare.

18.2 - Esta inmunización y/o servicios preventivos no están cubiertos.

18.3 - Las pruebas de mamografía para mujeres menores de 35 años no están cubiertas.

18.4 - Este servicio se denegó debido a que no han transcurrido (12-24) meses desde su último examen de este tipo.

18.5 - Medicare pagará por otra mamografía en (12-24) meses.

18.6 - Una mamografía de cernimiento es cubierta una vez solamente para mujeres entre las edades de 35-39.

18.7 - El examen Papanicolau es cubierto una vez cada tres años, a menos de que existan factores de alto riesgo.

18.8 - Una mamografía de cernimiento es cubierta una vez cada 24 meses a mujeres de 40-49 años de edad que no tengan factores de alto riesgo.

18.9 - Una mamografía de cernimiento es cubierta una vez cada 12 meses a mujeres de 40-49 años de edad que tengan factores de alto riesgo.

18.10 - Una mamografía de cernimiento es cubierta una vez cada 12 meses a mujeres de 50-64 años de edad.

18.11 - Una mamografía de cernimiento es cubierta una vez cada 24 meses a mujeres de 65 años o más de edad.

18.12 - El examen de mamografía de cernimiento se cubre una vez al año para mujeres de 40 años de edad o más.

18.13 - Este servicio no está cubierto para beneficiarios menores de 50 años de edad.

18.14 - Este servicio está siendo denegado ya que no han transcurrido (12,24,48) meses desde el último (examen/procedimiento) de esta clase.

18.15 - Medicare solamente cubre este procedimiento para beneficiarios con alto riesgo de contraer cáncer en el colon.

18.16 - Este servicio está siendo denegado ya que se ha hecho un pago por un procedimiento similar dentro del término de tiempo establecido.

18.17 - Medicare paga por el examen Papanicolau y/o examen pélvico (incluyendo un examen clínico del pecho) solamente una vez cada tres años, a menos que existan factores de alto riego.

18.18 - Medicare no paga por separado estos servicios, ya que el pago estaba incluido en nuestra asignación por otros servicios que usted recibió el mismo día.

18.19 - Este servicio no está cubierto hasta después de que el beneficiario cumpla 50 años.

90.19 - Servicios Médicos Prestados En Un Hospital

(Rev. 1, 10-01-03)

19.1 - Servicios de un especialista establecido en un hospital no son cubiertos, a menos que exista un acuerdo entre el hospital y el especialista.

19.2 - El pago se redujo debido a que este servicio fue realizado en un hospital como paciente no ingresado en lugar de la oficina del médico.

19.3 - Solamente una visita al hospital o consulta por proveedor es permitido por día.

90.20 - Límites En Los Beneficios

(Rev. 1, 10-01-03)

20.1 - Usted ha utilizado todos sus días de beneficios por este periodo.

20.2 - Usted ha llegado a su límite de 190 días de servicios psiquiátricos de hospital.

20.3 - Usted ha llegado a su límite de 60 días de reserva vitalicia.

20.4 - (____) de los días de beneficios usados fueron cobrados a sus beneficios de días de reserva vitalicia.

20.5 - Estos servicios no pueden ser pagados porque sus beneficios se han agotado.

20.6 - Los días usados han sido reducidos por el pago del asegurador de grupo primario.

20.7 - De sus 190 días por servicios de psiquiatría a los que tiene derecho, le quedan (____).

20.8 - Estos días han sido reducidos del total de sus días de beneficios como (paciente interno o de los días de beneficios de Hogar de Enfermería Especializada) para este periodo de beneficios.

20.9 - Los servicios recibidos después de mm/dd/yy no pueden ser pagados porque sus beneficios ya estaban agotados.

20.10 - Este servicio fue negado porque Medicare solamente paga hasta 10 horas de entrenamiento en la educación de la diabetes durante el período inicial de 12 meses. Nuestros expedientes indican que usted ya obtuvo 10 horas de entrenamiento.

20.11 - Este servicio fue negado porque Medicare solamente paga por 2 horas de continuación del entrenamiento en la educación de la diabetes durante un año. Nuestros expedientes indican que usted ya obtuvo 2 horas de entrenamiento por este año.

20.13 - Este servicio fue negado porque Medicare solo paga hasta 3 horas por terapia médica nutricional durante un año calendario. Nuestros expedientes indican que usted ya recibio 3 horas de terapia médica nutricional.

20.14 - Este servicio fue negado porque Medicare sólo paga 2 horas al año por servicios de seguimiento de la terapia médica nutricional. Nuestros expedientes indican que usted ya recibió 2 horas de servicios de seguimiento en este año.

90.21 - Restricciones A La Cobertura

(Rev. 1, 10-01-03)

21.1 - Servicios rendidos por un pariente inmediato o un miembro de la misma casa o familia no están cubiertos.

21.2 - El proveedor de estos servicios no es elegible para recibir pagos de Medicare.

21.3 - Este proveedor no estaba cubierto por Medicare cuando usted recibió los servicios.

21.4 - Servicios rendidos fuera de los Estados Unidos no son cubiertos. Consulte su Manual de Medicare para servicios recibidos en Canadá y Méjico.

21.5 - Servicios necesitados como consecuencia de una guerra no están cubiertos.

21.6 - Este servicio no está cubierto cuando es rendido, referido u ordenado por este proveedor.

21.7 - Este servicio debe ser incluido en su factura de paciente interno.

21.8 - Servicios rendidos usando equipo que no es aprobado por la Administración de Alimentos y Drogas no son cubiertos.

21.9 - Medicare no paga por servicios no autorizados fuera del plan de cuidado de la salud.

21.10 - Un asistente cirujano no está cubierto por este servicio y/o fecha del servicio.

21.11 - Este servicio no estaba cubierto por Medicare cuando usted lo recibió.

21.12 - Este servicio de hospital no fue cubierto porque el médico de cabecera no era elegible para recibir beneficios de Medicare cuando los servicios fueron prestados.

21.13 - Esta cirugía no está cubierta porque el médico no era elegible para recibir beneficios de Medicare cuando los servicios fueron prestados.

21.14 - Medicare no puede pagar por este artefacto experimental porque la Organización para la Administración de Alimentos y Medicinas (FDA) no ha iniciado el periodo clínico de prueba.

21.15 - Medicare no puede pagar por este artefacto experimental porque la Organización para la Administración de Alimentos y Medicinas (FDA) ha terminado el período clínico de prueba.

21.16 - Medicare no paga por este artefacto experimental.

21.17 - Su Proveedor sometió cargos no cubiertos por los cuales usted es responsable.

21.18 - Este servicio no está cubierto cuando es ordenado o rendido por este proveedor.

21.19 - El proveedor decidió renunciar al programa de Medicare. Ningún pago se puede hacer por este servicio. Usted es responsable por este cargo. Bajo la ley Federal, su médico no puede cobrarle más de la cantidad límitada establecida.

21.20 - El proveedor decidió renunciar al programa de Medicare. Ningún pago se puede hacer por este servicio. Usted es responsable por este cargo.

21.21 - Este servicio fue denegado porque Medicare solamente lo cubre bajo ciertas circunstancias.

21.22 - Medicare no paga por este servicio debido a que se considera de investigación y/o experimental en estas circunstancias.

90.22 - Reclamaciones Separadas

(Rev. 1, 10-01-03)

22.1 - Su reclamación fue separada para ser procesada. Los servicios restantes pueden aparecer en una notificación aparte.

90.23 - Cirugía

(Rev. 1, 10-01-03)

23.1 - El costo del cuidado antes y después de cirugía o procedimiento está incluido en la cantidad aprobada por ese servicio.

23.2 - Cirugía plástica y servicios relacionados no están cubiertos.

23.3 - Medicare no paga por aditamentos quirurgicos de apoyo, excepto por vendajes primarios para injertos de piel.

23.4 - Un cargo separado no es permitido debido a que este servicio es parte del procedimiento principal de cirugía.

23.5 - El pago se redujo debido a que un médico diferente le prestó cuidados antes y después de la cirugía.

23.6 - Esta cirugía fue reducida debido a que fue realizada con otra cirugía el mismo día.

23.7 - No se puede pagar a un cirujano asistente en un hospital de enseñanza, a menos que un médico residente no esté disponible.

23.8 - Este servicio no se paga debido a que es parte del cargo total del cuidado de maternidad.

23.9 - El pago se redujo debido a que los cargos facturados no incluyeron el cuidado después de la operación.

23.10 - El pago se redujo debido a que el procedimiento fue finalizado antes de que la anestesia fuera administrada.

23.11 - No se puede pagar debido que la cirugía fue cancelada o aplazada.

23.12 - El pago se redujo debido a que la cirugía fue cancelada después de que usted estaba preparado para la cirugía.

23.13 - Debido que a usted lo prepararon para la cirugía y la anestesia fue suministrada, el pago completo se hará, a pesar de que la cirugía fue cancelada.

23.14 - El asisente del cirujano debe enviar su reclamación por este servicio por separado.

23.15- La cantidad aprobada es menor porque el pago fue divido entre dos médicos.

23.16 - Una cantidad adicional no es permitida por este servicio cuando es realizado en ambos lados (izquierdo y derecho) del cuerpo.

90.24 - Mensajes Para Ayudar A Detener El Fraud

(Rev. 1, 10-01-03)

AB-02-106

24.1 - Proteja su tarjeta de Medicare como si fuera una tarjeta de crédito.

24.2 - No acepte ofertas de servicios o artículos de Medicare gratis o con descuentos.

24.3 - No acepte servicios o artículos de Medicare gratis que le ofrecen personas que visitan su hogar.

24.4 - Sólo su médico, quien conoce su historial de salud puede ordenarle equipo médico.

24.5 - Revise siempre su Resumen de Medicare. Asegúrese de que la información es correcta.

24.6 - No venda su número de Medicare o su Resumen de Medicare.

24.7 - No acepte servicios ni equipo médico gratis a cambio de número de Medicare.

24.8 - Esté alerta a avisos que digan “Este artículo está aprobado por Medicare” o “Sin gastos adicionales.”

24.10 - Manténgase informado, lea ambas partes de su Resumen de Medicare.

24.11 - Esté alerta a los fraudes contra Medicare, como regalos a cambio de su número de Medicare.

24.12 - Lea cuidaosamente su Resumen de Medicare y verifique las fechas, servicios y cantidades facturadas.

24.13 - Asegúrese de leer todos los papeles que tenga que firmar al recibir servicios bajo Medicare.

24.14 - Asegúrese que cualquier servicio o equipo médico que usted recibió fue ordenado por su médico.

90.25 - Tiempo Limite De Enviar La Reclamación

(Rev. 1, 10-01-03)

25.1 - Esta reclamación fue denegada debido a que fue sometida después del tiempo límite.

25.2 - A usted solamente se le puede facturar el 20 por ciento del costo total que hubiese sido aprobado.

90.26 - Visión

(Rev. 1, 10-01-03)

26.1 - Exámenes de refracción visual no son cubiertos.

26.2 - Espejuelos o lentes de contacto son cubiertos solamente después de una cirugía de catarata o si le falta el lente natural de su ojo.

26.3 - Solamente un par de espejuelos o lentes de contacto es cubierto después de cirugía de catarata con inserción de lente.

26.4 - Este servicio no es cubierto cuando es realizado por este proveedor.

26.5 - Este servicio es cubierto solamente en si se realiza conjuntamente con una cirugía de catarata.

26.6 - El pago se redujo debido a que el servicio fue terminado prematuramente.

90.27 - Hospicio

(Rev. 1, 10-01-03)

27.1 - Este servicio no es cubierto debido que usted está registrado(a) en un hospicio.

27.2 - Medicare no pagar por el cuidado temporero de paciente interno cuando ecxede 5 días consecutivos por cada ocasión.

27.3 - La certificación del médico solicitando servicios de hospicio no se recibió a tiempo.

27.4 - La documentación recibida indica que los servicios generales de paciente interno no estaban relacionados a la enfermedad terminal. Por lo tanto, el pago va a ser ajustado a la tarifa de cuidado rutinario en el hogar.

27.5 - El pago por el día que le dieron de alta del hospital se hará a la agencia de hospicio a la tarifa de cuidado rutinario en el hogar.

27.6 - La documentación indica que el nivel de cuidado era al nivel de cuidado temporero, no al nivel general de cuidado como paciente interno. Por lo tanto, el pago de Medicare va a ser ajustado a la tarifa de cuidado rutinario en el hogar.

27.7 - De acuerdo con los requisitos de hospicio de Medicare, el consentimiento para la elección del hospicio no fue firmado a tiempo.

27.8 - La documentación sometida no apoya que su enfermedad sea terminal.

27.9 - La documentación indica que su nivel de cuidado como paciente interno no fue razonable ni necesario. Por lo tanto, el pago va a ser ajustado a la tarifa de cuidado rutinario en el hogar.

27.10 - La documentación indica que el nivel de cuidado continuo no fue rasonable ni necesario. Por lo tanto, el pago va a ser ajustado a la tarifa de cuidado rutinario en el hogar.

27.11 - El proveedor facturó por error por los artículos de cuidado rutinario en el hogar o por los servicios recibidos.

27.12 - La documentación indica que su nivel de cuidado temporero no era razonable y necesaria. Por lo tanto, el pago será ajustado a la tarifa de cuidado rutinario en el hogar.

27.13 - Según requisitos de hospicio de Medicare este servicio no se cubre debido a que el servicio fue proporcionado por un médico no primario.

90.28 - Asignación Mandatoria

(Rev. 1, 10-01-03)

28.1 - Debido a que usted recibe beneficios de Medicaid, su proveedor debe estar de acuerdo en aceptar la asignación.

90.29 - MSP

(Rev. 1, 10-01-03)

29.1 - No se pueden hacer pagos secundarios debido a que la información de su asegurador primario fue omitida o incompleta.

29.2 - No se hizo ningún pago debido a que la cantidad que su asegurador primario pagó, cubrió la cuenta del proveedor.

29.3 - Los beneficios de Medicare fueron reducidos porque algunos de estos gastos fueron pagados por su asegurador primario.

29.4 - En el futuro, si usted envía reclamaciones a Medicare para pagos secundarios, favor de enviarlas a: (dirección contratísta MSP).

29.5 - Nuestros archivos indican que Medicare es su asegurador secundario. Esta reclamación deberá ser enviada a su asegurador primario. (Note: Use "Add-on" message as appropriate).

29.6 - Nuestros archivos indican que Medicare es su asegurador secundario. Servicios prestados fuera de su plan de salud no son cubiertos. Medicare pagará esta vez solamente porque usted no fue notificado previamente.

29.7 - Medicare no puede pagar por este servicio, pues lo realizó un proveedor que no es miembro de su plan patronal prepagado de salud. Nuestros archivos indican que a usted se le informó sobre esta regla.

29.8 - Esta reclamación fue denegada debido a que el servicio puede ser cubierto por el plan de compensación del trabajador. Solicite a su proveedor que envíe esta reclamación a ese seguro.

29.9 - Ya que los beneficios de su seguro primario han sido agotados, Medicare será su asegurador primario en este servicio que está relacionado con el accidente.

29.10 - Estos servicios no se pueden pagar porque usted los recibió en o antes de recibir un pago del seguro de responsabilidad pública por esta lesión o enfermedad.

29.11 - Nuestros archivos indican que un plan de seguro de automóviles o un seguro de otro tipo son primarios para este servicio. Envíe esta reclamación a su asegurador primario. (Note: Use "Add-on" message as appropriate.)

29.12 - Nuestros archivos indican que estos servicios pueden estar cubiertos bajo el programa Federal del Pulmón Negro (Black Lung). Comuníquese con el Labor Department, Federal Black Lung Program, P.O. Box 828, Lanham-Seabrook, MD 20703-0828. (Note: Use "Add-on" message as appropriate.)

29.13- Medicare no pagará estos servicios debido a que pueden ser pagados por otra agencia gubernamental. Envíe esta reclamación a esa agencia. (Note: Use "Add-on" message as appropriate.)

29.14 - El pago secundario de Medicare es ($_____). Esta es la diferencia entre la cantidad aprobada de ($_____) por el asegurador primario y la cantidad pagada de ($_____) por el asegurador primario.

29.15 - El pago secundario de Medicare es ($_____). Esta es la diferencia entre la cantidad aprobada por el Medicare de ($_____) y la cantidad pagada por asegurador primario de ($_____).

29.16 - Su asegurador primario aprobó y pagó ($_____) en esta reclamación. Por lo tanto no habrá pago secundario por el Medicare.

29.17 - Su proveedor accedió a aceptar ($_____) como pago completo en esta reclamación. Su asegurador primario ya ha pagado ($_____) por lo que el pago de Medicare es la diferencia entre las dos cantidades.

29.18 - La cantidad bajo la columna Podría Ser Facturado asume que su asegurador primario le pagó al proveedor. Si su asegurador primario le pagó a usted, entonces usted tiene la responsibilidad de pagarle al proveedor la cantidad que su asegurador primario le pagó a usted más la cantidad que aparece en la columna Podría Ser Facturado.

29.19 - La cantidad que aparece en la columna Podría Ser Facturado asume que su asegurador primario le pagó a usted. Si su asegurador primario le pagó al proveedor, entonces usted solamente tiene que pagarle al proveedor la diferencia entre la cantidad cobrada y la cantidad que el asegurador primario pagó.

29.20 - La cantidad que aparece en la columna Podría Ser Facturado asume que su asegurador primario le pagó a usted. Si su asegurador primario le pagó a su proveedor, entonces usted solamente tiene que pagarle al proveedor la diferencia entre la cantidad que el proveedor acordó aceptar y la cantidad que su asegurador primario pagó.

29.21 - La cantidad que aparece en la columna Podría Ser Facturado asume que su asegurador primario no pagó por este servicio. Si su asegurador primario pago por este servicio, la cantidad que a usted le pueden facturar es la diferencia entre la cantidad cobrada y el pago del asegurador primario.

29.22 - La cantidad que aparece en la columna Podría Ser Facturado asume que su asegurador primario le pagó a usted. Si su asegurador primario le pagó al proveedor, entonces usted solamente necesita pagarle al proveedor la diferencia entre la cantidad que el proveedor puede cobrar legalmente y la cantidad que su asegurador primario pagó. Vea la nota (__) para ver el límite de cargo legal.

29.23 - No se puede hacer un pago porque ya fue hecho o por la compensación de trabajadores o por el Programa Federal de Enfermedad Pulmonar Minera.

29.24 - No se puede hacer un pago porque ya fue hecho por otra entidad gubernamental.

29.25 - Medicare pagó todos los servicios cubiertos no pagados por otro asegurador.

29.26 - El pagador primario es _____.

29.27 - El pago de su grupo primario ha cumplido con el deducible y coaseguro de Medicare.

29.28 - Su responsibilidad en esta reclamación ha sido reducida por la cantidad pagada por su asegurador primario.

29.29 - Su proveedor está autorizado a cobrar un total de ($_____) en esta reclamación. Su asegurador primario pagó ($_____) y el Medicare pagó ($_____). Usted. es responsable por la porción restante de ($_____).

29.30 - ($_____) del dinero aprobado por su asegurador primario ha sido acreditado a su deducible de Medicare Parte B (A). Usted. no tiene que pagar esta cantidad.

29.31 - Favor de enviar la reclamación con la información omitida o incorrecta.

29.32 - El pago secundario de Medicare es de ($_____). Ésta es la diferencia entre la cantidad límite aprobada por Medicare de ($_____) y la cantidad pagada por el asegurador primario de ($_____).

90.30 - Cargos Razonables

(Rev. 1, 10-01-03)

30.1 - La cantidad aprobada está basada en un método especial de pago.

30.2 - El cargo permitido a la facilidad es mayor que la cantidad facturada.

30.3 - Su médico no aceptó la asignación por este servicio. Bajo la Ley Federal, su médico no puede cobrarle más de $_____. Si usted pagó más de esta cantidad, usted tiene derecho a un reembolso de su proveedor.

30.4 - Un cambio en el método de pago ha resultado en un pago reducido o ningún pago por este procedimiento.

30.5 - Esta syna es ka duferebcua ebtre ka cabtudad factyrada t ka cabtudad qye Neducare aprobó.

90.31 - Ajustes

(Rev. 1, 10-01-03)

31.1 - Esto es una corrección a una reclamación previamente procesada y/o a su deducible.

31.2 - Un pago ajustado fue procesado basado en una revisión telefónica.

31.3 - Esta notificación es enviada a usted como resultado de una petición de reapertura.

31.4 - Esta notificación es enviada a usted como resultado de su petición por una audiencia.

31.5 - Si usted no está de acuerdo con la cantidad aprobada por Medicare y $100 o más están en disputa (menos el deducible y coaseguro), puede solicitar una audiencia. Debe pedir esta audiencia dentro de 6 meses desde la fecha de esta notificación. Para llegar a los $100, puede combinar cantidades de otras reclamaciones que han sido revisadas. También puede presentar evidencia nueva. Favor de llamar al número indicado en la Sección de Servicios al Cliente si necesita información adicional sobre el proceso de la vista.

31.6 - Un pago ajustado fue hecho basado en una petición por la Organización para el Mejoramiento de la Calidad.

31.7 - Esta reclamación fue previamente procesada bajo un número/nombre de Medicare incorrecto. Nuestros archivos han sido corregidos.

31.8 - Esta reclamación fue ajustada para reflejar el proveedor correcto.

31.9 - Esta reclamación fue ajustada debido a un error en facturación.

31.10 - Este es un ajuste a un cargo procesado previamente. Es possible que esta notificación no refleje los cargos originalmente sometidos.

31.11 - La notificación que enviamos previamente indicó que su médico no puede cobrar más de ($_____). Este pago adicional permite que su médico le facture a usted la cantidad completa cargada.

31.12 - La notificación previamente enviada indicó la cantidad que a usted le pueden cobrar por este servicio. Este pago adicional cambió esa cantidad. Su médico no le puede cobrar más de ($_____).

31.13 - La cantidad pagada por Medicare ha sido reducida por ($_____) previamente pagado por esta reclamación.

31.14 - Este pago es el resultado de una decisión de un juez de derecho administrativo.

31.15 - Un adjuste fue hecho basado en una decisión de revisión.

31.16 - Un ajuste fue hecho basado en una reconsideración.

31.17 - Este es un ajuste interno. Usted no necesita hacer nada.

90.32 - Sobrepagos

(Rev. 1, 10-01-03)

32.1 - ($_____) de este pago ha sido retenido para recuperar un sobrepago anterior.

32.2 - Usted no debe ser facturado separadamente por sus doctores para servicios proporcionados durante esta hospitalización interna.

90.33 - Cuidado Quirurgico Ambulatorio

(Rev. 1, 10-01-03)

33.1 - El centro ambulatorio quirúrgico debe facturar por este servicio.

90.34 - Patient Paid/Split Payment

(Rev. 1, 10-01-03)

B-01-21

34.1 - Del total de ($_____) pagados en esta reclamación, nosotros le estamos pagando a usted ($_____) porque usted le pagó a su proveedor más del 20 por ciento del coaseguro de los servicios aprobados por Medicare. La cantidad restante ($_____), fue pagada al proveedor.

34.2 - La cantidad en la columna Podría Ser Facturado ha sido reducida por la cantidad que usted le pagó al proveedor, cuando los servicios fueron prestados.

34.3 - Después de aplicar los reglamentos de Medicare y la cantidad que usted le pagó al proveedor cuando los servicios fueron prestados, nuestros archivos indican que usted tiene derecho a un reembolso. Favor de comunicarse con su proveedor.

34.4 - Le estamos pagando a usted ($_____) porque la cantidad que usted le pagó al proveedor fue más de lo que a usted se le puede facturar por cargos que Medicare aprueba.

34.5 - La cantidad que le debemos es ($_____). Medicare normalmente no imprime cheques por cantidades inferiores a $1.00. Esta cantidad será incluida en su próximo cheque. Si usted desea esta cantidad inmediatemente, por favor pongase en contacto con nosotros en la dirección o número de teléfono indicado en la sección “Información de Servicios al Cliente.”

34.6 - Este cheque incluye la cantidad de ($_____) la cuál fue retenida en una reclamación anterior.

34.7 - Este cheque incluye una cantidad menor de $1.00 la cual fue retenida en una reclamación anterior.

34.8 - La cantidad que usted le pagó al proveedor por esta reclamación es mayor que la cantidad requerida. Usted deberá recibir un reembolso de $XX de su proveedor, la cual es la diferencia entre la cantidad que usted pagó y la que debió haber pagado.

34.9 - Si usted ya pagó a el suplidor/proveedor, el suplidor/proveedor debe devolver cualquier cantidad que exceda la cantidad del pago de Medicare.

90.35 - Cubierta Suplementaria/ Medigap

(Rev. 1, 10-01-03)

35.1 - Esta información será enviada a su asegurador privado. Envíe cualquier pregunta con respecto a sus beneficios a ellos. Su asegurador privado es _____.

35.2 - Hemos enviado su reclamación a su asegurador de Medigap. Envíe cualquier pregunta con respecto a sus beneficios a ellos. Su asegurador de Medigap es _____.

35.3 - No se enviará copia de esta notificación a su asegurador de Medigap debido a que la información estaba incompleta o era inválida. Favor de someter una copia de esta notificación a su asegurador Medigap.

35.4 - No se enviará una copia de esta notificación a su asegurador Medigap debido a que su proveedor no es participante del programa de Medicare. Favor de enviar la notificación a su asegurador Medigap.

35.5 - No se envió esta reclamación a su asegurador privado. Ellos indicaron que no pueden hacer un pago adicional. Favor de dirigir sus preguntas relacionadas con sus beneficios a ellos.

35.6 - Su póliza suplementaria no es una póliza Medigap bajo las leyes/regulaciones del estado o Federales. Es su responsabilidad radicar una reclamación directamente con su asegurador.

35.7 - Por favor no someta esta notificación a ellos.

90.36 - Reclamaciones Cuando Se Acepta Asignación

(Rev. 1, 10-01-03)

36.1 - Nuestros archivos indican que usted fue informado por escrito, antes de recibir el servicio, que Medicare no pagaría. Usted es responsable por esta cantidad. Si usted no está de acuerdo, usted puede pedir una revisión.

36.2 - Aparentemente, usted no sabia que nosotros no pagamos por este servicio, por lo tanto usted no es responsable. Si usted le pagó al proveedor por este servicio debe enviarnos lo siguiente: (1) Copia de esta notificación; (2) Factura del proveedor; (3) El recibo o prueba de que usted le pagó. Debe enviar su petición por escrito dentro de 6 meses de la fecha de esta notificación. Servicios de este tipo prestados en el futuro serán su responsabilidad.

36.3 - Su proveedor ha sido notificado de su derecho a un reembolso si pagó por este servicio. Si usted no recibe un reembolso de este proveedor dentro de 30 días desde el recibo de esta notificación, favor de escribir a nuestra oficina incluyendo copia de esta notificación. Su proveedor tiene el derecho de apelar esta decisión, la cual podría cambiar su derecho al reembolso.

36.4 - Este pago reembolsa la cantidad total que usted le pagó a su proveedor por (los) servicios previamente procesados y denegados. Usted tiene derecho a este reembolso porque su proveedor no le informó por escrito antes de prestarle el servicio(s) que Medicare no pagaría por el (los) servicio(s) denegado(s). En el futuro, usted tendrá que pagar por este servicio cuando sea denegado.

36.5 - Este pago le reembolsa a usted la cantidad total a la que usted tiene derecho por servicios previamente procesados y reducidos. Usted tiene derecho a este reembolso porque su proveedor no le informó por escrito antes de prestarle el servicio que Medicare aprobaría una cantidad menor. En el futuro, usted tendrá que pagar la cantidad total facturada cuando sea reducida.

36.6 - Medicare está pagando esta reclamación, solamente esta vez porque parece que ni usted. ni su proveedor, sabían que los servicios iban a ser denegados. En el futuro, pagos por este tipo de servicio serán su responsabilidad.

90.37 - Deducible/Coaseguro

(Rev. 1, 10-01-03)

37.1 - La cantidad aprobada ha sido aplicada a su deducible.

37.2 - Una parte de esta cantidad aprobada ha sido aplicada a su deducible.

37.3 - ($_____) fue aplicado a su deducible de hospital.

37.4 - ($_____) fue aplicado a su coaseguro de hospital.

37.5 - ($_____) fue aplicado a su coaseguro de Instalación Enfermería Especializada.

37.6 - ($_____) fue aplicado a su deducible de sangre.

37.7 - El deducible en efectivo de la Parte B no aplica a estos servicios.

37.8 - La cantidad de coaseguro incluye la limitación para el tratamiento de enfermedad mental de paciente ambulatorio.

37.9 - Usted ha cumplido con ($_____) de sus ($_____) del deducible de la Parte B para (año).

37.10 - Usted ha cumplido con ($_____) de sus ($_____) del deducible de la Parte A cubiertos por este periodo de beneficios.

37.11 - Usted ha cumplido con el deducible de la Parte B para (año).

37.12 - Usted ha cumplido con el deducible de la Parte A por este periodo de beneficios.

37.13 - Usted ha cumplido con el deducible de sangre para (año).

37.14 - Usted ha cumplido con ($_____) pinta(s) de su deducible de sangre.

90.38 - Sección De Información General

(Rev. 1, 10-01-03)

AB-02-106

38.3 - Si usted cambia de dirección, favor de llamar al (contractor's name) al (contractor's telephone number) y a la Oficina del Seguro Social al 1-800-772-1213.

38.4 - Usted está en alto riesgo para complicaciones de la influenza y es muy importante que usted se vacune. Favor de comunicarse con su proveedor del cuidado de la salud para la vacuna contra la influenza.

38.5 - Si usted no ha recibido su vacuna contra la influenza no es demasiado tarde. Favor de comunicarse con su proveedor del cuidado de la salud sobre recibir la vacuna contra la influenza.

38.6 - El cáncer colorectal es el segundo cáncer principal que ataca en los E.E.U.U. Sin embargo, pruebas de investigación pueden encontrar pólipos antes de que lleguen a ser cancerosos. También pueden encontrar el cáncer temprano cuando el tratamiento trabaja lo mejor posible. Medicare ayuda a pagar por pruebas de investigación. Comuníquese con su doctor sobre las opciones de pruebas de investigación que son apropiadas para usted.

38.7 - Medicare cubre las pruebas de investigación del cáncer colorectal que pueden encontrar pólipos precancerosos en el colon y recto. Los pólipos pueden ser removidos antes de que sean cancerosos. Comuníquese con su doctor sobre hacerse la prueba.

38.8 - Enero es el mes de la prevención del cáncer cervical.

38.9 - La prueba de papanicolao (o prueba pap) es la manera más efectiva de examinar el cáncer cervical.

38.10 - Compare los servicios que usted recibe con los que aparecen en su Resumen de Medicare. Si tiene preguntas, llame a su doctor o proveedor. Si usted cree que se necesita investigar más debido a un posible fraude o abuso, llame al teléfono que aparece en la sección Información de Servicios al Cliente.

90.41 - Agencia De Servicios De Salud En El Hogar (HHA)

(Rev. 1, 10-01-03)

41.1 - Medicare solamente paga por este servicio cuando es proporcionado en adición a otros servicios.

41.2 - Este servicio debe ser desempeñado por una enfermera psiquiátrica con los credenciales requeridos.

41.3 - La información médica no apoyó la necesidad para continuar los servicios.

41.4 - Medicare no considera que este artículo es apropiado para el uso en el hogar.

41.5 - Medicare no paga por artículos de comodidad ni de conveniencia.

41.6 - Este servicio no fue proporcionado bajo un plan de cuidado establecido por su médico.

41.7 - Medicare no considera este artículo como ortopédico ni como una prótesis.

41.8 - Basado en la información proporcionada, su enfermedad o su lesión no le impedía dejar su hogar sin ayuda.

41.9 - Los servicios proporcionados excedieron los que su médico ordenó.

41.10 - Los pacientes elegibles para recibir beneficios de servicios de salud en el hogar de otra agencia gubernamental no son elegibles para recibir beneficios similares bajo Medicare.

41.11 - Las instrucciones de su médico estaban incompletas.

41.12 - El proveedor facturó por error por estos artículos o servicios de acuerdo al record médico.

41.13 - El proveedor facturó por servicios o artículos no documentados en su record.

41.14 - Este servicio o artículo fue facturado incorrectamente.

41.15 - Esta información demuestra que usted puede hacerse cargo de su cuidado personal.

41.16 - Para recibir el pago de Medicare, usted deberá tener una orden firmada por su médico antes de recibir los servicios.

90.42 - Servicios De Cuidado De Salud No Médico Religioso

(Rev. 1, 10-01-03)

AB-00-30

42.1 - Usted recibió cuidado médico en una facilidad diferente a una institución de cuidado de salud no médico religioso, pero ese cuidado no cancela su elección de recibir beneficios por cuidado de salud no médico religioso.

42.2 - Como usted recibió cuidados médicos en una facilidad diferente a una institución de cuidado de salud no médico religioso, su elección de recibir beneficios por servicios de cuidado de salud no médico religioso ha sido cancelado por estos servicios, a menos que usted solicite una nueva elección.

42.3 - Este servicio no está cubierto porque usted no eligió recibir servicios de cuidado de salud no médico religioso, en vez de los servicios regulares de Medicare.

42.4 - Este servicio no está cubierto porque usted recibió servicios de cuidados de salud médicos, lo cual cancela su elección a servicios de cuidado de salud no médico religiosos.

42.5 - Este servicio no está cubierto porque usted solicitó por escrito que su selección para recibir servicios de cuidado de salud no médico religioso sea cancelado.

100 - Spanish Add-On Messages

(Rev. 1, 10-01-03)

9.3 - Por favor solicite a su proveedor que nos envíe una nueva reclamación completa.

9.7 - Le hemos pedido a su proveedor que envíe la reclamación con la información omitida o incorrecta.

15.16 - Su reclamación fue revisada por nuestro personal médico.

15.17 - Hemos aprobado este servicio con un índice de pago reducido.

16.34 - Usted no debería ser facturado por este servicio. Usted no tiene que pagar esta cantidad.

16.35 - Usted no tiene que pagar esta cantidad.

16.36 - Si usted ya lo ha pagado, tiene derecho a un reembolso de su proveedor.

16.37 - Por favor vea al dorso de esta notificación.

16.45 - Usted no puede ser facturado separadamente por este artículo o servicio. Usted no tiene que pagar esta cantidad.

25.2 - A usted solamente se le puede facturar el 20 por ciento del costo total que hubiese sido aprobado.

29.26 - El pagador primario es _____.

35.7 - Por favor no someta esta notificación a ellos.

29.31- Favor de enviar la reclamación con la información omitida o incorrecta.

110 - Spanish Mandated Messages

(Rev. 1, 10-01-03)

120 - Projecto Especial (Demostraciones)

(Rev. 1, 10-01-03)

AB-01-30, AB-01-97, AB-01-149, B-00-48

60.1 - (Name of Hospital) en cooperación con médicos en su área, están participando en una demostración de Medicare el cual utiliza un método de pago simplificado que combina todos los hospitales y médicos relacionados a sus servicios de hospital.

Este pago sencillo va a hacer el proceso de facturación más fácil mientras que mantiene el costo más bajo o al mismo nivel de como era bajo el sistema tradicional de pago.

60.2 - La cantidad total que Medicare aprobó por sus servicios de hospital es de ($_____). ($_____) es la cantidad de Medicare Parte A por sus servicios de hospital y ($_____) es la cantidad de Medicare Parte B por sus servicios médicos (de los cuales Medicare paga el 80%). Usted es responsable por cualquier deducible y coaseguro presentado más abajo.

60.3 - Medicare pagó ($_____) por servicios de hospital y por servicios médicos. Su deducible de la Parte A es ($_____). Su coaseguro de la Parte A es ($_____). Su coaseguro de la Parte B es ($_____). Su deducible de la Parte A para sangre es ($_____).

60.4 - Esta reclamación está siendo procesada bajo un projecto especial.

60.5 - Esta reclamación se está procesando bajo el proyecto de demonstración. Si usted desea más información sobre este proyecto, favor de llamar al 1-888-289-0710.

60.6 - Una reclamación de reembolso ha sido sometida en su nombre indicando que usted está participando en el Projecto de Prueba de Cuidado de Salud Coordinado de Medicare. Sin embargo, nuestros archivos indican que usted no está afiliado al presente o su afiliciación todavía no ha sido aprobada para participar en este projecto de prueba.

60.7 - Una reclamación de reembolso ha sido sometida en su nombre indicado que usted está participando en el Projecto de Prueba de Cuidado de Salud Coordinado de Medicare. Sin embargo, nuetros archivos indican que usted o decidió terminar su participación en el projecto de prueba o los días de servicios están excluídos de los días de participación del projecto de prueba.

60.8 - La cantidad aprobada está basada en lo máximo permitido para este artículo bajo el proyecto de Equipo Médico Duradero Protésico, Ortótico y Suministros (DMEPOS, por sus siglas en inglés).

60.9 - Nuestros expedientes indican que este paciente empezó el uso de este servicio(s) antes de la ronda actual de Equipo Médico Duradero Protésico, Ortótico y Suministros (DMEPOS, por sus siglas en inglés). Por lo tanto, la cantidad aprobada está basada en la autorización que estaba en efecto antes de la ronda actual para este artículo.

60.10 - Aunque este servicio está siendo pagado de acuerdo con las reglas y normas bajo el proyecto de Equipo Médico Duradero Protésico, Ortótico y Suministros (DMEPOS, por sus siglas en inglés), reclamaciones futuras pueden ser denegadas cuando este artículo es suministrado al paciente por un proveedor que no participa en la demonstración. Si usted desea más información referente a este proyecto, puede llamar al 1-888-289-0710.

60.11 - Este pago está siendo retirado debido a que los servicios proporcionados están cubiertos bajo el proyecto de demostración en que el hospital recibe el pago para todos los servicios médicos y del hospital relacionados a esta admisión. El proveedor debe procurar el reembolso directamente del hospital en donde el cuidado fue proporcionado. Cualquier deducible o coaseguro pagado por usted o su asegurador suplementario para estos servicios debería ser devuelto por su proveedor.

90.15 – Necesidad Medica