Medicare
Carriers Manual
Part 3 - Claims Process

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

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CHANGE REQUEST 2602

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
3110 – 3116	3-67 – 3-69 (3pp.)	3-67 – 3-69 (3pp.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE:* July 1, 2003
IMPLEMENTATION DATE: July 1, 2003

Section 3110, Disposition of Misdirected Claims, contains new information about CPT rules for misdirected claims sent to the Durable Medical Equipment Regional Carriers (DMERCs).

Section 3116, Parenteral and Enteral Nutrition (PEN) Claims Jurisdiction, has been deleted because the information in this section is obsolete.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

These instructions should be implemented within your current operating budget.

3110. DISPOSITION OF MISDIRECTED CLAIMS

This section applies to misdirected claims that are payable by local carriers and have been sent to the wrong carrier or are payable by the Railroad Retirement Board (RRB), the United Mine Workers of America (UMWA), the Indian Health Service (IHS) but have been mistakenly sent to the local carrier. This section also applies to claims that are payable by Durable Medical Equipment Regional Carriers (DMERC) and have been sent to the wrong DMERC. Current processes per the DMERC statement of work should be followed for misdirected claims that have mistakenly been sent to the wrong DMERC. It does not apply to misdirected claims that are payable by a DMERC, but have mistakenly been sent to the local carrier or vice versa. DMERCs and carriers should continue with current claims processing procedures for these claims.

A. A Local Carrier Receives a Claim with Some or All Services that are in Another Local Carrier's Payment Jurisdiction.--When you receive a request for Medicare payment for services furnished outside of your payment jurisdiction, (see §3005.1), return assigned services as unprocessable, and deny unassigned services. Pay services correctly submitted to you.

Use the following messages:

Remittance Advice (RA)

Claim adjustment reason code 109 – Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.

New remark code N104 - This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS Web site at www.cms.hhs.gov.

Medicare Summary Notice (MSN)

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.

Spanish - 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.

B. A Local Carrier Receives a Claim for an RRB Beneficiary.--When you receive a request for Medicare payment from a provider for RRB beneficiaries, per §3005, return as unprocessable assigned services and deny unassigned services. Pay services correctly submitted to you.

Use the following messages:

RA

Claim adjustment reason code 109 – Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.

New remark code N105 - This is a misdirected claim/service for a RRB beneficiary. Submit paper claims to the RRB carrier: Palmetto GBA, P.O. Box 10066, Augusta, GA 30999. Call 866-749-4301 for RRB EDI information for electronic claims processing.

MSN

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.

Spanish - 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.

NOTE: The CMS requests that when RRB receives a claim that is not for an RRB beneficiary that they return the claim to the sender and notify them that the claim must be submitted to the local carrier or DMERC for processing.

C. A Local Carrier Receives a Claim for an UMWA Beneficiary.--When you receive a request for Medicare payment that should be processed by the UMWA, per §3005, return as unprocessable assigned services and deny unassigned services.

Use the following messages:

RA

Claim adjustment reason code 109 – Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.

New remark code N127 - This is a misdirected claim/service for a United Mine Workers of America beneficiary. Submit paper claims to: UMWA Health and Retirement Funds, PO Box 389, Ephraim, UT 84627-0361. Call Envoy at 1-800-215-4730 for information on electronic claims submission.

MSN

11.11 - This claim/service is not payable under our claims jurisdiction. We have notified your provider to send your claim for these services to the United Mine Workers of America for processing.

11.11 - Esta reclamación/servicio no se paga bajo nuestra jurisdicción de reclamaciones. Le hemos notificado a su proveedor que debe enviar la reclamación por estos servicios a la Unión de Trabajadores Mineros de América.

D. Misdirected HMO Claims.--Handle misdirected claims/services for HMO enrollees in accordance with §4267.1.

E. Transfer of Claims Between DMERCs.--If a provider erroneously submits to you a claim that must be paid by another DMERC, forward such claims to the DMERC that has processing responsibility under Medicare jurisdiction rules. Claims Processing Timeliness rules (Part II, MCM §5240) do not begin for misdirected claims/services until the proper DMERC receives the claim/service.

3110.1 Transfer of Claims Material Between Carrier and Intermediary.--If a beneficiary erroneously submits to you an HCFA-1490S with an itemized bill for services that must be paid by the Part A intermediary, forward such claims to the intermediary for the necessary action.

3110.2 Signature Requirements.--In the situation described in § 3110.1, intermediaries have been instructed to obtain hospital billings (including SSA-1554's) if necessary and that the patient's signature on the SSA-1490 satisfied the signature requirement for the hospital billings. Carrier will occasionally receive from hospitals SSA-1554's lacking a patient's signature but showing in the signature block an entry substantially as follows: "Patient's signature on SSA-1490 retained by Part A intermediary." The carrier is authorized to make payment on the basis of this entry.

3115. PAYMENTS UNDER PART B FOR SERVICES FURNISHED BY SUPPLIERS OF SERVICES TO PATIENTS OF A PROVIDER

Payment for certain medical and other health services can be made either to the provider who arranges for the services or to the supplier of the services. (See §2255.) For this purpose, a nonparticipating skilled nursing facility will be considered a supplier. If a participating provider or nonparticipating hospital arranges for these services, it should submit billings to the intermediary on the appropriate provider billing form (SSA-1483). If the supplier does not provide the services under arrangements with a provider, it can either accept an assignment and bill the carrier on an SSA-1490 or furnish the patient with an itemized bill.

Where a supplier regularly furnishes covered medical and other health services to inpatients of a provider or nonparticipating hospital, either the intermediary or the carrier should always be billed for such services so that billing does not vary on a case-by-case basis. The same billing arrangements should also continue to apply after a beneficiary exhausts his Part A benefits so that further benefits in that spell of illness are covered only under Part B.

The intermediary should ascertain whether the provider or supplier will bill for the services and notify the carrier of the billing arrangements. The carrier should confirm the supplier's understanding of the arrangements.

When a supplier furnishes these medical and other health services to patients of more than one institution, it need not make the same arrangements with all of them; that is, the supplier could arrange for one provider to bill for all services furnished to its inpatients, and the supplier could bill directly all inpatients of another provider to whom it furnishes services.

Since payment can be made under Part A only for services furnished by a provider "under arrangements" with the supplier, i.e., the provider bills the program, suppliers and providers should be encouraged to arrange for the provider to bill the program.

Any billing submitted which is inconsistent with the agreed arrangements should be rejected, and the provider or supplier (or beneficiary) who billed the program should be advised that the claim must be refiled in the proper manner.