
Program Memorandum Intermediaries

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

Transmittal A-02-117

Date: NOVEMBER 1, 2002

CHANGE REQUEST 2336

SUBJECT: Correction to Updated Instruction on Receipt and Processing of Non-Covered Charges on Other Than Part A Inpatient Claims (Transmittal A-02-071)

Transmittal A-02-071 gave instructions on how the Common Working File (CWF) and Fiscal Intermediary (FI) standard systems (SSs) are to accept non-covered charges on a claim. These instructions stand as published, except for the correction below.

Formerly, this section of Transmittal A-02-071 read as follows:

Condition Codes 20 and 21

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

If a beneficiary demands a Medicare determination for any line(s) for other than Home Health services, instruct the provider to put those line(s) on a separate bill showing the charges as non-covered and put condition code 20 on the bill. If a beneficiary wants an MSN for denial reasons on any line(s) for other than Home Health services, put those line(s) on a separate bill and show condition code 21 on that bill. The SS will generate denial reasons for the lines containing non-covered charges. Home Health services are addressed in a previous section of this instruction.

Note: The use of occurrence code 32 should be made specific to all claim types except Home Health bills. Since there is only one occurrence code (32) to indicate the date the beneficiary received an ABN, only lines for which you notified the beneficiary on the same date may be submitted on the same bill for both demand bills and billing for denial bills (condition codes 20 and 21). If you gave ABNs on different dates for different procedures, show the services and the dates you gave ABNs on separate bills for each date involved

This section is now revised to read:

Condition Codes 20 and 21, Occurrence Code 32

If an FI receives a completely non-covered claim with either a condition code 20 or a condition code 21, process the claim through all systems.

Beneficiaries are assumed to be liable on claims using condition code 21, since these claims, sometimes called “no-pay bills” and having all non-covered charges, are submitted to Medicare to obtain a denial that can be passed to subsequent payers. An advance beneficiary notice (ABN) is not required in these cases. If an ABN is given, condition code 21 cannot be used.

Claims with condition code 20 may be submitted with both covered and non-covered charges. An ABN, specifically Form R-131, should not be employed when condition code 20 is used. Note that condition code 20 may be used when: (1) a Home Health (HH) ABN, Form R-296, is used because

CMS Pub. 60A

payment will be made under the HH Prospective Payment System (PPS); or (2) a hospital or SNF inpatient notice of non-coverage is provided, since a Form R-131 will not be given in these cases.

Claims are billed with condition code 20 at a beneficiary's request, where the provider has already advised the beneficiary that Medicare is not likely to cover the service(s) in question. Providers may directly collect payment from beneficiaries in such cases for non-covered charges, but if, upon review, Medicare decides a service in question is actually covered and pays, providers must return any payment collected from beneficiaries for these services. Medicare reviews all home health (HH) and skilled nursing facility (SNF) services in question on these bills using condition code 20 to make a payment determination.

Occurrence code 32 on a claim signifies that an ABN, Form R-131, was given to a beneficiary on a specific date. This code must be employed if this specific ABN form is given, and condition code 20 will not be used on the subsequent claim (i.e., no charges will be submitted as non-covered). All services on such claims with occurrence code 32 must be covered charges, even if the result of full adjudication of these claims is expected to be that services will be found to be non-covered. If such services are non-covered after full adjudication, the beneficiary remains liable for the services. If instead, as a result of medical review, Medicare finds services are covered, the Medicare Program becomes liable since the provider will receive payment direct from Medicare.

Note: The use of a provider ABN, Form R-131 and occurrence code 32 can apply to all outpatient or institutional Part B services, with three exceptions. One, only a HHABN, Form R-296 and condition code 20, can apply to HH PPS services. Two, the provider ABN, Form R-131, and occurrence code 32 are to be used when needed for hospice services paid under either Trust Fund A or Trust Fund B. Three, a totally separate process will be used for ambulance claims containing non-covered miles; a new PM is currently in development for this ambulance situation.

Only services for which the ABN was given should be shown on the claim with occurrence code 32, since the code pertains to every service on the claim. Providers must give separate ABNs for different procedures if performed on different dates, and show the services and the dates ABNs were given on separate bills for each date involved. The one exception is that only one ABN is required for a series of services given under standing orders.

If a service not pertaining to the ABN was rendered in the same period as service(s) requiring an ABN, such services must be submitted on separate claims, and the statement dates of these claims cannot overlap. **If the time periods cannot be separated (i.e., a service requiring an ABN is given on the same day a service not requiring an ABN), a single claim must be submitted, just for the overlapping period, using occurrence code 32, showing all services as covered, and placing modifier GA on the HCPCS code to identify the service (revenue code) line for which the ABN (CMS R-131) was given.** Since this is an exception process, providers are reminded to use this mechanism only when it is impossible to separate the billing periods.

The final instance in which beneficiaries are liable for non-covered charges is for services they request be billed to Medicare, but Medicare does not cover by statute. Examples of services not covered by statute include personal comfort items, hearing aides and hearing examinations, routine eye and dental care. Medicare claims processing edits are being refined to effectuate the processing of such claims. Providers should advise beneficiaries each time they are aware services not covered by statute are being requested before Medicare is billed, but ABNs are not to be used in these cases.

If, in a situation in which giving an ABN, Form R-131 is not appropriate, a beneficiary demands a Medicare determination for any line(s) for other than HH PPS services, instruct the provider to put those line(s) on a separate bill showing the charges as non-covered and put condition code 20 on the bill. If a beneficiary wants an MSN for denial reasons on any line(s), instruct the provider to put those line(s) on a separate bill and show condition code 21 on that bill. If the provider gives the beneficiary an ABN under any other circumstances, the provider must show the charges as covered and also put occurrence code 32 on the claims to fix beneficiary liability. There are no provider billing requirements for billing services excluded by statute other than billing such items as non-

covered. The SS will generate denial reasons for the lines containing non-covered charges. HH PPS services are addressed in a previous section of this instruction.

Systems Changes

This correction requires changes to FI shared systems. First, both systems must permit acceptance of condition code 20 with non-covered charges for all outpatient bill types. Second, these systems must RTP (return to providers) any bill containing occurrence code 32 and condition code 20 or 21. Third, the systems must RTP claims with occurrence code 32 if they: (1) contain non-covered charges, or (2) overlap any other claims billed by the same provider for the same beneficiary for the same time period. Fourth, FI systems must permit use of HCPCS modifier GA as follows:

Modifier	Definition	Use
GA	Waiver of Liability [ABN] on file	Provider submitted on any FI-processed claim with Occurrence Code 32 when applicable (i.e., when only some services on a claim link to an ABN). Not required if all services on the claim with Occurrence Code 32 link to an ABN.

Provider billing instructions have changed with this correction. If providers have automated this part of their billing process, their billing systems may also require changes.

The *effective date* for this PM is claims with dates of service on and after January 1, 2003.

The *implementation date* for this PM is January 1, 2003. (The same as Transmittal A-02-071.)

These instructions should be implemented within your current operating budget.

This PM may be discarded after April 1, 2004.

If you have any questions, you may contact **Cindy Murphy** at 410-786-5733 or cmurphy1@cms.hhs.gov or **Antoinette Johnson**, ajohnson2@cms.hhs.gov, or **Elizabeth Carmody**, ecarmody@cms.hhs.gov.