Medicare
Intermediary Manual
Part 3 - Claims Process

Department of Health & Human Services (DHHS)

Centers for Medicare & Medicaid Services (CMS)

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CHANGE REQUEST 2115

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
3686.1 - 3690.1	6-513 - 6-516 (4 pp.)	6-513 - 6-516 (4 pp.)
3693.5 – 3693.5 (Cont.)	6-577 - 6-580 (4 pp.)	6-577 - 6-580 (4 pp.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE: June 10, 2002*
IMPLEMENTATION DATE: June 10, 2002

Section 3686.1, Further Development Is Not Necessary, provides instructions on the reporting of retirement dates in relation to Medicare Secondary Payer (MSP) occurrence codes 18 and 19.

Section 3686.2, Further Development Is Required, includes Web-site references related to X12N 837 formats.

Section 3693.5, Methodology for Review of Hospital Billing Data, provides instructions on the reporting of retirement dates in relation to MSP occurrence codes 18 and 19. (This language is being added in relation to FLs 32 thru 36—Occurrence Codes and Dates.)

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.

3686. DEVELOPMENT OF CLAIMS WHERE THERE MAY BE OTHER PAYER INVOLVEMENT

Where Medicare is indicated as primary payer on Form CMS-1450, also known as the UB-92, assume in the absence of evidence to the contrary, that the provider has correctly determined that there is no other primary coverage and process the claim accordingly. There are instances in which further development is necessary, as discussed in §3686.2.

3686.1 Further Development Is Not Necessary.--Medicare providers are required by law to obtain other payer information and to certify that such development has occurred. Submission of the following types of information by a hospital is to be accepted without further inquiry:

- Claim containing a MSP value code and payment amount;
- Condition codes 05, 09, 10, 11, 26, 28, and 29 are shown on bill;
- Occurrence codes 05, 06, 12, 20, 23, 24, 25, 18, 19, and dates are shown on bill;
- Use of remarks field for further clarification;
- Claim denied because active MSP record, but claim not filed as MSP;
- MSP claim filed and information on claim matches MSP CWF record; and
- MSP record shows "not active," and claim was filed with Medicare as primary payer.

When such information is submitted, do not attempt further development. The bill automatically updates CWF in the preceding situations. Your hospital reviews must ensure that bill submissions are proper and comply with the law's requirements. (See §3693.)

In relation to the reporting of occurrence codes 18 and 19, as referenced above, hospitals are now instructed in §301 of the Hospital Manual that when precise retirement dates cannot be obtained during the intake process, they should follow this policy:

When a beneficiary cannot recall his/her retirement date but knows it occurred prior to his/her Medicare entitlement dates, as shown on his/her Medicare card, report his/her Medicare A entitlement date as the date of retirement. If the beneficiary is a dependent under his/her spouse's group health insurance and the spouse retired prior to the beneficiary's Medicare Part A entitlement date, report the beneficiary's Medicare entitlement date as his/her retirement date.

If the beneficiary worked beyond his/her Medicare A entitlement date, had coverage under a group health plan during that time, and cannot recall his/her precise date of retirement but you determine it has been at least 5 years since the beneficiary retired, enter the retirement date as 5 years retrospective to the date of admission. (That is, if the date of admission is January 4, 2002, report the retirement date as January 4, 1997, in the format you are currently using.) As applicable, the same procedure holds for a spouse who had retired at least 5 years prior to the date of the beneficiary's hospital admission.

If a beneficiary's (or spouse's, as applicable) retirement date occurred less than 5 years ago, you must obtain the retirement date from appropriate informational sources; e.g., former employer or supplemental insurer.

3686.2 Further Development Is Required.--Develop the claim only when the following billing situations occur:

o Condition code 08 is shown on bill;

o Claim with primary insurer identification, no primary payer amounts, and nothing indicated in remarks field;

o Beneficiary has a black lung CWF record, and bill is submitted with a black lung diagnosis,but without the primary payment amount shown or without an EOB, or without remarks, which denies the black lung claim;

o MSP claim filed with very low primary payment (investigate for possible keying error with provider to ensure accurate payment amount);

o Trauma diagnosis, no MSP record, and claim does not show occurrence code 05 and date nor remarks;

o Retirement dates same as dates of service (i.e., improper use of occurrence codes 18 and 19);

o Occurrence codes 01-04 used, but not MSP claim. No occurrence code 24 or remarks and no value code and zero dollar showing request for conditional payment; and MSP value code and payment amount shown conflict with CWF record.

NOTE: For those using X12N 837 formats, the following is provided to assist in your implementation efforts. The Medicare A 837 health care claim version 305 implementations 3A, 01 and 1A.C1 (Appendix C of both documents have UB-92 mapping), formats are effective through October 16, 2003. The X12N 837 version 4010 (HIPPAA) to UB-92 version 6.0 mapping is at www.hcfa.gov/medicare/edi/hipaddoc.htm. The 837 version 4010 can be downloaded at 222.wpc-edi.com.

3688. DEDUCTIBLE AND/OR COINSURANCE RATES APPLICABLE ON MEDICARE SECONDARY CLAIMS WHEN AN INPATIENT STAY SPANS TWO CALENDAR YEARS

Where Medicare is secondarily liable because another payer primary to Medicare has made payment on an inpatient claim and the stay spans 2 calendar years, the provider bills the deductible and/or coinsurance rate applicable to the year in which Medicare utilization is charged. Medicare utilization (calculated in accordance with §§3682.1.B.3 and 3685.A.3) is charged beginning with the first day of the stay. This rule applies even though the primary payer paid for only a specified number of days of a stay, e.g., the primary payer's plan covers the first 20 days of a 30 day stay.

Where Medicare utilization involves coinsurance days spanning 2 calendar years, the provider bills coinsurance for each coinsurance day in accordance with the applicable coinsurance rate for the year in which the day was used. The provider uses value codes 09 and 11, form locators 46 through 49, to show specific coinsurance amounts. See CWF documentation for reporting coinsurance days on the CWF RECORD.

EXAMPLE l:

A beneficiary is in a new benefit period and was admitted to the hospital on December 15, 1992 and discharged on January 14, 1993. An insurer primary to Medicare paid the first 20 days of the stay. The provider bills $652 deductible (the applicable deductible for the first year in which Medicare utilization is charged).

EXAMPLE 2:

A beneficiary was admitted to the hospital on December 15, 1992 and discharged on January 14, 1993. Only coinsurance days were available. An insurer primary to Medicare paid the first 20 days of the stay. After performing the utilization calculation, the provider determined the beneficiary can be charged with 10 days utilization (December 15 thru December 24). The provider bills 10 days coinsurance at the 1992 rate ($163 x 10 = $1,630). The coinsurance amount is based upon the inpatient hospital deductible for the year in which days are used.

EXAMPLE 3:

A beneficiary was admitted to the hospital on December 25, 1992 and discharged on January 24, 1993. Only coinsurance days were available. An insurer primary to Medicare paid the first 20 days of the stay. After performing the utilization calculation, the provider determined the beneficiary can be charged with 10 days utilization (December 25, 1992 thru January 3, 1993). The provider bills 7 days coinsurance at the 1992 rate ($163 x 7 = $1,141) and 3 days coinsurance at the 1993 rate ($169 x 3 = $507). The coinsurance amount is based upon the inpatient hospital deductible for the year in which days are used. The data is reported on the CMS-1450 as follows:

Value Code 09, Medicare Coinsurance Amount in First Calendar Year	$	1,141.00
Value Code 11, Medicare Coinsurance Amount in Second Calendar Year	$	507.00
Form Locator 25, Coinsurance Days		10
Form Locator 61, Coinsurance Amount	$	1,648.00

3690. COORDINATION WITH PROVIDERS

Billing is an important process and can best be facilitated when you and your providers communicate effectively with each other, particularly where questions arise. Providers must have direct access to you. Therefore, you must:

- Furnish answers to provider questions within 30 days or less from the time the question is received;
- Encourage conversations between your staff and the provider;
- Provide names and phone numbers of contact persons, including their specific areas of expertise;
- Provide special contacts for troubleshooting situations;
- Attempt the clearest possible communication by providing clear and consistent answers/guidance; and
- Return voice mail or other phone messages within 24 hours of the time the call is received. If the caller requests a response which requires investigation, use the time frame stipulated above (within 30 days) to respond. The initial call must be returned within 24 hours to inform the provider that the question is being researched.

3690.1 Returning Bills to Providers.--In order to identify and bill other insurers properly, it is essential that the insurer name field of the MSP auxiliary record contain accurate information.

The CWF will no longer recognize the following entries as insurer or payer names:

- CMS;
- Medicare (when entered with nothing following);
- None;
- No (followed by a space or low values);
- N/A;
- N/A (followed by a space or low values);
- Unknown;
- UNK;
- Attorney;
- Insurer;
- Supplement, Supplemental;
- BC, BX, BCBX, BS, Blue Cross, or Blue Shield with no other characters following;
- Any entry containing less than two characters;
- Commercial (when entered with nothing following); and
- Miscellaneous (or Misc.).

Return bills to providers whenever there are inaccurate or inappropriate designations in this field. The provider must conduct development with the beneficiary or insurer to verify identification of the other payer. Once the other payer is properly identified, the bill may be resubmitted for processing.

The bill universe shall consist of Medicare inpatient, outpatient, and subunit claims for which a primary or secondary Medicare payment was made. Select the sample using the following criteria:

- o At least 2/3 of the sample should consist of inpatient bills. The remaining 1/3 is to be outpatient bills. The split is to be determined at the reviewer's discretion;
- o The sample must contain a minimum of 20 bills and a maximum of 60 bills;
- o Include Medicare no-pay bills in the sample in order to examine the ratio of no-pay bills submitted by the hospital to those actually billed;
- o The sample is to include a mixture of bill types from the hospital's bill universe. Accordingly, if the hospital does not submit ESRD bills, then the reviewer is not required to review that particular bill type; and
- o Both Medicare primary and secondary bills are to be included in the sample.

3693.5 Methodology for Review of Hospital Billing Data.--

A. Entrance Interview.--Conduct an entrance interview with the billing staff to determine whether the hospital established (1) policies concerning billing other payers, and (2) a system in which such policies are carried out in practice. Both these areas are to be examined in one interview. Use the checklist found in §3693.8, Exhibit 4 to conduct the entrance interview. During the interview, request a walk-through of the billing process.

B. Comparing Completed Admission Questionnaire With Bills.--Request completed inpatient, outpatient, and ER admission questionnaires (or screen prints for hospitals using on-line admission query systems) for each Medicare beneficiary included in the bill sample. (See §3693.4 concerning selection of sample.) The completed questionnaire must be kept on file for 10 years in accordance with the Department of Justice's (DOJ's) general record retention requirements. It is not necessary that the completed questionnaire be signed by the beneficiary.

The form may be kept as paper, optical image, microfilm, or microfiche. If the hospital uses on-line admission screens, it is not necessary to obtain a copy of an admission form or screen print as long as the hospital has documented procedures for collecting and reporting other primary payer information. You may request screen prints, if necessary. Hospitals with on-line query systems are required to retain affirmative and negative responses to the questionnaire for 10 years after the date of service in accordance with DOJ's general record retention requirements. On-line data may not be purged before then.

Analyze the admission questionnaire, or on-line admission query procedures, for Medicare beneficiaries to determine whether the information provided on the questionnaire matches the bill. Check to see whether each response to the questionnaire is reflected on the bill. For example, check to ensure that the primary payer reflected on the questionnaire is shown as primary on the bill, name and address of insurer(s) on questionnaire matches that on the bill, etc. You should check this admissions information at the same time you conduct the bill review.

C. Review of Form CMS-1450.--Obtain all Form CMS-1450s, also known as the UB-92s, which are included in the sample. Separate the bills according to bill type. Determine the amount billed to Medicare for each case. Review Form CMS-1450 for the following MSP data to determine if the billed amount is accurate and to conduct the comparison process using the admissions questionnaire described at §3693.5B. Item numbers reflect Form CMS-1450 field locators. (See §3604 for a complete definition of these items.)

1. General Review Requirements.--Review the following items, which are not specific to a particular bill type.

FLs 24 thru 30 - Condition Codes.--The following condition codes must be completed where applicable:

08 - Beneficiary would not provide information concerning other insurance coverage
09 - Neither patient nor spouse employed
10 - Patient and/or spouse is employed, but no GHP
28 - Patient and/or spouse's GHP is secondary to Medicare

FLs 32 thru 36 - Occurrence Codes and Dates.--The following occurrence codes must be completed where applicable:

18 - Date of retirement (patient/beneficiary)
19 - Date of retirement (spouse)
24 - Date insurance denied
25 - Date benefits terminated by primary payer (date on which coverage, including workers' compensation benefits or no-fault coverage, is no longer available to patient)

In relation to the reporting of occurrence codes 18 and 19, referenced above, hospitals are now instructed in §301 of the Hospital Manual that when precise retirement dates cannot be obtained during the intake process, they should follow this policy:

When a beneficiary cannot recall his/her retirement date but knows it occurred prior to his/her Medicare entitlement dates, as shown on his/her Medicare card, report his/her Medicare A entitlement date as the date of retirement. If the beneficiary is a dependent under his/her spouse's group health insurance and the spouse retired prior to the beneficiary's Medicare Part A entitlement date, report the beneficiary's Medicare entitlement date as his/her retirement date.

If the beneficiary worked beyond his/her Medicare A entitlement date, had coverage under a group health plan during that time, and cannot recall his/her precise date of retirement but you determine it has been at least 5 years since the beneficiary retired, enter the retirement date as 5 years retrospective to the date of admission. (That is, if the date of admission is January 4, 2002, report the retirement date as January 4, 1997, in the format you are currently using.) As applicable, the same procedure holds for a spouse who had retired at least 5 years prior to the date of the beneficiary's hospital admission.

If a beneficiary's (or spouse's, as applicable) retirement date occurred less than 5 years ago, you must obtain the retirement date from appropriate informational sources; e.g., former employer or supplemental insurer.

FLs 39 thru 41 - Value Codes and Amounts.--Value codes and amounts should be completed to show the type of the other coverage and the amount paid by the other payer for Medicare covered services.

Where the hospital is requesting conditional payment, zeros should be entered beside the appropriate value code in this item.

FL 50A - Payer Identification--Payer identification should be completed to show the identity of the other payer primary to Medicare. All additional entries across line A (FLs 51-55) supply information needed by the payer named in FL 50A.

FLs 50 B, C - Payer Identification.--Payer identification should be completed to show when Medicare is the secondary or tertiary payer.

FL 58A - Insured's Name.--The insured's name should be completed to show the name of the individual in whose name the insurance is carried. This information is of particular importance when Medicare is not the primary payer.

In FL 58B, the hospital should have entered the patient's name as shown on the HI card or other Medicare notice or as annotated in the hospital's system.

FL 59 - Patient's Relationship to the Insured.--This item indicates whether the individual may have coverage based on the current employment status of a spouse or other family member.

FLs 60A, B, C - Certification/SSN/HICN.--On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information is shown in FLs 50-54, the hospital should have entered the patient's Medicare HICN. If the hospital is reporting any other insurance coverage higher in priority than Medicare (e.g., employer coverage for the patient or the spouse or during the first 30 months of ESRD entitlement), the involved claim number for that coverage should be shown on the appropriate line.

2. Working Aged Bills.--

FLs 39 thru 41 - Value Codes and Amounts.--The following value codes and amounts should be completed to show the type of other coverage and the amount paid by the other payer for Medicare covered services.

12 - Working aged/beneficiary/spouse with group health plan coverage

3. Accident Bills.--

FLs 39 thru 34 - Occurrence Codes and Dates.--The following occurrence codes should be completed to show the type and date of the accident:

01 - Auto accident
02 - Auto accident with no-fault insurance
03 - Accident involving civil court process
04 - Employment related accident
05 - Other accident

FLs 39 thru 41 - Value Codes and Amounts.--The following value codes and amounts should be completed to show the type of the other coverage and the amount paid by the other payer for Medicare covered services:

14 - Automobile, or other no-fault insurance
47 - Any liability insurance

When occurrence codes 01 thru 04 and 24 are entered, they must be accompanied by the entry of the appropriate value code in FLs 39-41 (shown here) if there is another payer involved.

4. Workers' Compensation Bills.--

FLs 24 thru 30 - Condition Codes.--Condition codes should be completed with condition code 02 if the condition is employment related.

FLs 39 thru 41 - Value Codes and Amounts.--The following value codes and amounts should be completed to show the type of other coverage and the amount paid by the other payer for Medicare covered services.

15 - Workers' compensation

5. ESRD Bills.--

FLs 39 thru 41 - Value Codes and Amounts.--The following value codes and amounts should be completed to show the type of other coverage and the amount paid by the other payer for Medicare covered services.

13 - ESRD beneficiary in 30-month period with group health plan coverage

6. Bills for Federal Government Programs.--

FLs 39 thru 41 - Value Codes and Amounts.--The following value codes and amounts should be completed to show the type of other coverage and the amount paid by the other payer for Medicare covered services:

16 - PHS, other Federal agency
41 - Black lung

7. Disability Bills.--

FLs 39 thru 41 - Value Codes and Amounts.--The following value codes and amounts should be completed to show the type of other coverage and the amount paid by the other payer for Medicare covered services.

43 - Disabled beneficiary with large group health plan coverage

D. Use of Systems Files for Review.--Use your paid history files, MSP control files, and any other relevant data to assist you in evaluating hospital procedures used in processing claims included in the sample. The purpose of a review is to determine whether the hospital has filed any improper claims. This can be accomplished by reviewing certain files before the on-site review, and other files after the review, subject to your judgment concerning the most effective use of a particular file. The following areas should be reviewed against your internal files:

- Claims denied to determine whether a hospital is using information from an admission questionnaire properly;
- Claims paid to determine if proper amounts are being billed;
- No pay bills. Check your files to determine if the hospital is submitting these;
- Adjustments to determine whether an automatic adjustment was needy. Reviewer may exercise discretion in determining what documentation is needed to justify the adjustment made; and
- IRS/SSA/HCFA data match denials to determine whether claim reflects change in the beneficiary's current employment status.

In cases where you ascertain that an improper claim has been filed, document these instances on the assessment form. (See §3693.8, Exhibit 1.)