Medicare
Carriers Manual
Part 3 - Claims Process

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

Transmittal 1792 **Date: MARCH 28, 2003**

CHANGE REQUEST 2473

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
4267 – 4267.1	4-65 – 4-66 (2pp.)	4-65 – 4-66 (2pp.)

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

Section 4267.1 Claims Processing Procedures for Physician/Supplier Services to HMO Members, is revised.

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.

Reimbursement for non-member services furnished on a fee basis are made through you in all cases and are subject to a "reasonable charge" determination. The plan may bill the patient directly or accept assignment in these instances.

4265. BILLING BY ORGANIZATIONS ON CMS-1500 OR CMS-1490U

Organizations request payment on either Forms CMS-1500 or CMS-1490U.

The Form CMS-1490U may be used by organizations which prefer to bill on a single form. This form combines the necessary information from Form CMS-1500 with a certification statement required in accordance with §7065D.

Instructions for completion of CMS-1490U form are on the reverse of the form. (See §4999, Exhibit 5.)

The organization completes all necessary information in Part I of either the Form CMS-1500 or Form CMS-1490U. This includes:

- Patient's name, HICN, sex, and address. The address is shown in item 4 of Form CMS-1500.

- Organizational name, address, and approval number in Item 5 of Form CMS-1490U. When Form CMS-1500 is used, the equivalent information of Item 5 must be shown on an attachment. (See §7065D.)

- ICD-9-CM coding is required for each diagnosis and must correlate to each procedure or service rendered by a physician beginning April 1, 1989. See §4030.2, Item 23A for additional information.

- Signature of an authorized organization official. When Form CMS-1500 is used, the signature will be shown on the organization's attachment.

The claim form need not be signed by the enrollee. The organization should furnish sufficient itemization of the services it has paid for (with diagnosis, dates of services, places of service, and charges) to enable a reasonable charge determination to be made. This may be done by submitting Part II of Form CMS-1500, signed by the physician or an itemization on the attached physician's bill form(s).

4267. HEALTH MAINTENANCE ORGANIZATION (HMO) - CLAIMS FOR PHYSICIAN/SUPPLIER SERVICES FURNISHED TO HMO MEMBER

Process claims for items or services provided to an HMO member over which you have jurisdiction (see §9050.2) in the same manner as you process other Part B claims for items or services provided by physicians or suppliers. (See §§40l0-4265 and 4270-4272.l.)

NOTE: See §§9050ff. for HMO qualifications and for conditions of payment to HMO's.

4267.1 Claims Processing Procedures for Physician/Supplier Services to HMO Members.--Generally, the physician/supplier who provides in-plan services to its HMO members submits his bill directly to the HMO for payment and normally does not get involved in processing the claim. (See §9050C.) However, in some cases, claims for services to HMO members are also submitted to carriers, e.g., where claims are received from physicians for dialysis and related services provided through a related dialysis facility.

If the CWF reply (trailer 05) indicates that the patient is a member of an HMO, take appropriate action as described below based on the code shown in the trailer portion of the CWF reply.

The Beneficiary is a Member of an HMO for only a Portion of the Bill.--A bill may include services furnished when the beneficiary was a member and services furnished when the beneficiary was not a member of an HMO. Contractors must process the non-member portion of the claim and deny the HMO portion to the biller along with claim level remittance advice message 109 instructing the service provider to submit a claim to the beneficiary's HMO for the denied services. If the patient was an HMO member for all the services on the claim, deny the entire claim with message 109.

4267.2 Procedures for Handling Claims Transferred by the HMO.--HMOs may send billings to you for various reasons. Resolve the issue by requerying or recontracting the HMO, if necessary, and take appropriate action as follows:

- If the beneficiary is not a member of a HMO, process the claim.