Business Requirements

Pub. 100-4	Transmittal:25	Date: October 31, 2003	Change Request 2634

SUBJECT: Billing Non-Covered Charges to Fiscal Intermediaries – Summary and New Instructions

I. GENERAL INFORMATION

A. Background:

This instruction summarizes existing instructions related to the billing of non-covered charges by providers submitting fee-for-service claims to Medicare fiscal intermediaries (FIs) or regional home health intermediaries (RHHIs). While inpatient facilities have been able to bill these charges for some time, Medicare systems have only had end-to-end capacity to process non-covered charges for outpatient providers on claims with other covered charges as of April 2002 (prior transmittals: A-01-130, A-02-071, A-02-117 and A-03-039.) This document does provide some new instructions, but only to the extent that current instructions did not provide enough specificity on certain aspects of billing, or failed to apply broad concepts to all bill types, especially in association with liability-related notices such as the advance beneficiary notice (ABN). Instructions on the ABN and HHABN (Home Health ABN) can be found in transmittals AB-02-168, A-03-025 and A-03-24.

B. Policy:

This instruction supplements published transmittals A-01-130, A-02-071, A-02-117 and A-03-039. It also serves to effect compliance with the Health Insurance Portability and Accountability Act (HIPAA), in assuring all services not covered by Medicare may be submitted and accepted on Medicare claims, which in turn can be crossed-over to subsequent payers.

C. Provider Education:

Intermediaries shall inform affected providers by posting either a summary or relevant portions of this document on their Web site within the shortest period warranted by the circumstances. Also, intermediaries shall publish this same information in their next regularly scheduled bulletin. If they have a listserv that targets affected providers, they shall use it to notify subscribers that information about "Billing Non-Covered Charges to Fiscal Intermediaries – Summary and New Instructions" is available on their Web site.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement #	Requirements	Responsibility
	2634.1 Series of Requirements – General Non-Systems	
2634.1	FIs/RHHIs should not advise providers to independently adjust or cancel finalized claims, including line items submitted as non-covered and denied, since providers	FIs§

	should only be requesting such adjustments be done by the FI/RHHI, especially when such action could result in altering a medical review decision or affecting final payment, with exceptions as noted in the Adjustments section of Chapter One on General Claims in the Medicare Claims Processing Manual (§130 of Chapter 1).	
	2634.2 Series of Requirements – Inpatient Bills only	
2634.2	For claims with type of bill (TOB) 11x, 18x, 21x or 41x, assure claims submitted with frequency code zero have all non-covered charges, with total covered charges equaling zero, **or** total charges equal to total non-covered charges.	FI standard systems
2634.2.1	If this condition is not met, return the claim to the provider.	FI standard systems
	2634.3 Series of Requirements - Inpatient and Outpatient Bills	
2634.3	Allow all TOBs to use condition code 20 **or** 21 on a given claim with non-covered charges.	FI standard systems
2634.3.1	Return claims using condition code 21 to providers if **any** covered charges appear on the claim **and/or** if a frequency code other than 7, 8 or 0 (zero) is submitted in the TOB.	FI standard systems
2634.3.2	Return all claims using condition code 21 to providers if modifiers signaling provider liability are used on these claims (i.e., -EY, -GZ, -QL, -TQ)	FI standard systems
2634.3.3	Allow condition code 20 to be billed on all TOBs, except 32x and 33x, **but** allow on 32x and 33x only when the frequency code is 9 (on TOBs 329 and 339).	FI standard systems
2634.3.3.1	Allow claims with condition code 20 to be entirely non-covered, **or** to have as few as one non-covered charge line.	FI standard systems
2634.3.3.2	Return all claims received using condition code 20 to providers if containing all covered charges (i.e., at least one non-covered charge must appear on the claim), **and/or** if not using the correct frequency code as described in 2634.3.2.	FI standard systems
2634.3.3.3	Return claims using condition code 20 to providers if the statement covers dates of such claims overlap with the statement covers dates of another of the same provider's claims with a covered charge for the same beneficiary. [**NOTE:** Since these claims may be found covered upon review or appealed, and no more than one statement period should be affected by the simultaneous submission of two claims.]	FI standard systems
2634.3.3.4	Suspend all claims with condition code 20 for medical review of non-covered charges.	FI standard systems
2634.3.3.4.1	Other than HH (TOBs 32x and 33x) and SNF inpatient (TOB 21x) bills, for which CMS has mandated 100 percent review, medically review non-covered charges on all	FIs

	condition code 20 demand bills, sending TOBs 11x to Quality Improvement Organizations - QIOs (formerly Peer Review Organizations - PROs) for medical necessity determinations (other determinations, such as coverage and payment liability are done by the FI), determining liability for such charges in the course of review between Medicare (charges found to be covered) and the beneficiary (charges denied).	
	2634.4 Series of Requirements – Outpatient* No Payment Bills	
2634.4	For claims with outpatient TOBs*, assure claims submitted with all non-covered charges-- with total covered charges equaling zero, or total charges equaling total non-covered charges--have condition code 20 **or** 21 present on the claim.	FI standard systems
2634.4.1	If this condition is not met, return the claim to the provider.	FI standard systems
2634.4.2	For claims with outpatient TOBs*, submitted with condition code 21, allow these claims to be submitted by the same provider for the same beneficiary simultaneous to submission of claims with covered charges or condition code 20, however, assure that statement date period of the non-covered charge claim is equal to or fits within the statement date period of a claim with covered charges or condition code 20, if such claims are present. [**NOTE:** Since non-covered claims may be appealed, no more than one statement period should be affected by the simultaneous submission of two claims.]	FI standard systems
2634.4.2.1	Return other claims with covered charges or condition code 20 to providers if the claims' statement covers dates overlap those of a previously received non-covered charge claim, such that the statement covers date of the non-covered charge claim does not equal or fit within the statement covers period of a covered charge or condition code 20 claim.	FI standard systems
2634.4.3	Deny all non-covered charges submitted on condition code 21 claims, and hold the beneficiary liable.	FI standard systems
	2634.5 Series of Requirements – Outpatient* ABN Billing	
2634.5	For all outpatient* TOBs, require all claims received with occurrence code 32 to contain only covered charges **unless** modifier –GA appears on any line item of the claim [**NOTE:** The presence of –GA on line items means line items without the –GA on the same claim do not tie to an ABN; line items not tied to the ABN may be submitted as covered or non-covered. This instruction is an intentional	FI standard systems

	revision to CR 2590 requiring all charges be covered when occurrence code 32 is used.]	
2634.5.1	Return these claims to providers if any non-covered charges appear and the –GA is not used on any line item.	FI standard systems
2634.5.2	Return to providers any claim using occurrence code 32 if condition codes 20 or 21 also appear on that claim.	FI standard systems
2634.5.3	Allow multiple occurrences of occurrence code 32 on these claims.	FI standard systems
2634.5.4	Suspend claims for development that contain occurrence code 32.	FI standard systems
2634.5.4.1	Medically review claims with occurrence code 32 , focusing on covered charges associated with the ABN, **and** if review cannot be accomplished, allow claims to complete processing.	FIs
2634.5.4.2	Hold beneficiaries liable for all denied services on claims using occurrence code 32 EXCEPT if the –GA modifier is present on **any** line of the claim; when this modifier is present, hold the beneficiary liable if the line is submitted with –GA, hold providers liable if neither the –GA nor any other modifier signifying beneficiary liability is present (i.e.,-GL, -GY, -TS).	FI standard systems
	Also see requirements 2634.6.1, 2634.4 – 2534.4.4 and 2634.6.14.1.1 in modifier section.	
	2634.6 Series of Requirements – Modifiers	
2634.6	Deny any line item submitted as non-covered with a line-item HCPCS modifier that by definition is either non-covered **or** non-payable by Medicare (see Attachment B, III.G., Table 5, first row below titles).	FI standard systems
2634.6.1	Hold the provider liable for these denials **unless** CMS instructions for discrete modifiers specify to hold the beneficiary liable (see attachment, Section III. H., second table, specifically modifiers -GA, -GL, -GY, -TS), or for all lines on a claims using occurrence code 32 if no –GA modifier appears on that claim.	FI standard systems
2634.6.2	Return to providers any claims submitted with line-item modifier –GK.	FI standard systems
2634.6.3	If the modifier –EY is received on non-covered line items with TOBs 13x, 14x, 21x, 22x, 32x, 33x, 34x, 81x or 82x, deny the line item as provider liable.	FI standard systems
2634.6.3.1	For these TOBs, return claims to providers with –EY **and** any modifier requiring covered charges (-GA, -KB) on the same line.	FI standard systems
2634.6.3.2	If the modifier –EY is received on line items with covered charges on claims with TOBs 13x, 14x, 21x, 22x, 32x, 33x, 34x, 81x or 82x with covered charges, return the claim to the provider.	FI standard systems

2634.6.4	On all outpatient TOBs*, if the modifier –GA is used on a claim with occurrence code 32, require the modifier –GA to be submitted on at least one line item with covered charges.	FI standard systems
2634.6.4.1	Return claims to providers if the line item modifier –GA is used on a line with non-covered charges.	FI standard systems
2634.6.4.2	Return claims to providers if occurrence code 32 is not present when the –GA modifier is used.	FI standard systems
2634.6.4.3	If line(s) using the modifier –GA are denied, hold the beneficiary liable.	FI standard systems
2634.6.4.4	Return claims to providers if they contain a line items using both HCPCS code A9270 and the –GA modifier. [A9270 required non-covered charges, -GA covered charges.]	FI standard systems
2634.6.5	Accept modifier –GL on non-covered line items with TOBs 32x, 33x, and 34x only.	FI standard systems
2634.6.5.1	Return claims to providers if the –GL modifier is submitted on line items with covered charges **and/or** TOBs other than as listed in 2634.5.	FI standard systems
2634.6.5.2	When non-covered line item(s) submitted with the modifier –GL are denied, hold the beneficiary liable.	FI standard systems
2634.6.6	Return claims to providers if the –GY modifier is submitted on a line with covered charges.	FI standard systems
2634.6.6.1	When non-covered line item(s) submitted with the modifier –GY are denied, hold the beneficiary liable.	FI standard systems
2634.6.7	Return claims to providers if the –GZ modifier is used on a line item with covered charges.	FI standard systems
2634.6.7.1	When non-covered line item(s) submitted with the modifier –GZ are denied, hold the provider liable.	FI standard systems
2634.6.8	If the –KB modifier is used, require the –KB modifier be submitted on a line with covered charges on TOBs 32x, 33x, 34x.	FI standard systems
2634.6.8.1	Return claims to providers if the –KB modifier is submitted on line items with non-covered charges **and/or** on claims with TOBs other than 32x, 33x or 34x.	FI standard systems
2634.6.8.2	Suspend claims for development if –KB modifier is submitted on a non-covered line.	FI standard systems
2634.6.8.2.1	Develop claims with the -KB modifier and determine liability; do not hold the beneficiary liable **unless** development of the claim shows a reason to hold the beneficiary liable.	RHHIs
2634.6.8.2.2	Educate providers that the –KB modifier should not be used on a line item unless there is a reason that more than two or four modifiers have to be used when a beneficiary requests a DME upgrade. [**NOTE:** Many provider systems will not allow the submission of more than 2 modifiers, in	RHHIs

	such cases, despite the official definition and the capacity of the FISS and APASS systems to take in four modifiers on a line with direct EDI submission, educate that it is appropriate to use this modifier when three modifiers are needed if there is a two-modifier limit.]	
2634.6.9	Require modifiers –TQ **or** –QL to be submitted on a line with non-covered charges.	FI standard systems
2634.6.9.1	Return claims to providers if this condition is not met.	FI standard systems
2634.6.10	Return claims to providers if the –TQ **or** –QL modifier is submitted on TOBs other than 12x, 13x, 22x, 23x, 83x or 85x.	FI standard systems
2634.6.10.1	Return claims to providers if this condition is not met.	FI standard systems
2634.6.11	When non-covered line item(s) submitted with the modifiers –QL or –TQ are denied, hold the provider liable.	FI standard systems
2634.6.12	Return claims to providers if the –TS modifier is submitted on a line with covered charges.	FI standard systems
2634.6.12.1	When non-covered line item(s) submitted with the modifier –TS are denied, hold the beneficiary liable.	FI standard systems
2634.6.13	Assure that HCPCS code A9270 will be accepted when submitted with non-covered charges on all outpatient TOBs*.	FI standard systems, OCE (both versions)
2634.6.14.1	Deny all line items using A9270 and hold providers liable **unless** modifiers -GL, -GY, -KB or –TS appear.	FI standard systems
2634.6.14.1.1	When these modifiers are used, or if modifier –GA is used, or for all line items on claims using occurrence code 32 when no –GA modifier is present on the claim, hold the beneficiary liable, **and** modify OCE W7009 and W0235 as needed.	FI standard systems, OCE
2634.6.15	Return claims to providers if line-item modifiers are billed on non-covered line items without the use of a HCPCS code.	FI standard systems
	2634.7 Series of Requirements – Outpatient Therapies	
2634.7	Return claims to providers when the same outpatient therapy codes (TOBs and HCPCS in §10 thru §40.5 in Chapter 5 (outpatient therapies) of the Medicare Claims Processing Manual (formerly §3653, Part 3, of the Medicare Intermediary Manual) to be billed for the same patient by the same provider on the same day on both a covered and non-covered claim.	FI standard systems
	2634.8 Series of Requirements - Ambulance	
2634.8	Assure that HCPCS code A0888 will be accepted when submitted with non-covered charges on TOBs 12x, 13x, 22x, 23x, 83x or 85x.	FI standard systems, OCE (both versions)

2634.8.1	Return to providers claims with non-covered line(s) with covered charges on the line reflecting obsolete instructions	FI standard systems
2634.8.2	For denied line items when HCPCS code A0888 and the –GY modifier are used for the circumstance of miles beyond the closest facility, use Group Code PR and Reason Code 96 on the remittance, and use Message 1.1 on the MSN.	FI standard systems
2634.8.3	Pass non-covered line items with the modifier –TQ to PS&R	FI standard systems
2634.8.3.1	Display non-covered ambulance charges that use the modifier -TQ	PS&R
	2634.9 Series of Requirements - Screening Frequency Benefits	
2634.9	Assure medical necessity is the primary reason for denial of screening frequency benefits by using appropriate ANSI remittance reason codes and MSN messages as provided in Attachment B, Table 8	FI standard systems
	2634.10 -.18 Series of Requirements - General Non-covered Charge Systems Requirements	
2634.10	When the provider is liable **and** no other messages are specified for line items submitted as non-covered charges and denied, use group code CO and reason code 96 on the remittance, and Medicare Summary Notice (MSN) messages 16.58.	FI standard systems
2634.11	When the beneficiary is liable **and** no other messages are specified for line items submitted as non-covered charges and denied, use group code PR and reason code 96 on the remittance, and Medicare Summary Notice (MSN) message 16.10.	FI standard systems
2634.12	Bypass duplicate edits on entirely non-covered claims, **or** on non-covered line items, received on all outpatient* TOBs UNLESS the history claim has been medically reviewed.	FI standard systems
2634.13	Bypass Part B duplicate edits on entirely non-covered claims ,**or** non-covered line items, received on all outpatient* TOBs.	CWF
2634.14	Bypass A-B crossover edits for entirely non-covered claims, **or** non-covered line items, received on all outpatient TOBs.	CWF
2634.15	Bypass utilization edits for entirely non-covered claims, **or** non-covered line items, received on all outpatient* TOBs.	CWF
2634.16	Bypass consistency edits on entirely non-covered claims, **or** non-covered line items, received on all outpatient* TOBs, if the consistency edits are specific to particular billing situations, **NOT** if the edits relate to validity of data in required claim elements (ex., HIC number, provider	CWF

	number).	
2634.17	Use the R no-payment code consistently for all outpatient claims, including home health, for which any of spell information, co-payment or deductible must be updated.	RHHIs
2634.18	Update home health value codes 62-65 when the R code is used with zeros, since these value codes are needed to effectuate information related to the A-B Shift in the home health spell.	FI Standard Systems
2634.19	Update the dates of earliest and latest billing activity Date of Earliest Billing Activity (DOEBA) and Date of Latest Billing Activity (DOLBA) associated with the benefit period (not the episode) when the R no payment code is used on home health claims, and bypass consistency edits based on the R no payment code.	CWF

* For "outpatient"—see Attachment A.

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions
2634.2-2634.3.3.4; 2634.4-2634.5.4; 2634.5.4.2-2634.6.8.2; 2634.6.9-2634.8; 2634.8.2-2634.8.2.1; 2634.11-2634.16; 2634.18	Inputs are claims as described in these requirements
2634.8.1, 2634.9, 2634.10	Outputs are the remittance and MSN

B. Design Considerations:

X-Ref Requirement #	Recommendation for Medicare System Requirements
2634.3.3.4	Consider use of distinct reason codes for different TOBs being reviewed
2634.5.4	Consider use of medical policy parameters by users instead of shared system coding
2634.13-.16	Cost avoids should not be part of the bypass logic (no-pay codes E, F, G, H, J, K, Q, T, U, V, Y, 00, 12, 13, 14).

C. Interfaces:

The Outpatient Code Editor (OCE) **may** require changes for requirements 2634.6.13, 2634.6.14.1.1 and 2634.8. PS&R will have to make changes for requirement 2634.8.2.1.

D. Contractor Financial Reporting/Workload Impact:

New medical review is called for, but an offsetting savings to this cost is that publication of this instruction should help reduce inquiries related to non-covered charges.

E. Dependencies:

None.

F. Testing Considerations:

None.

IV. OTHER CHANGES

Citation	Change
	N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: April 1, 2004, for services provided on or after October 1, 2000, on claims submitted on or after April 1, 2004, within the timely filing period. **Implementation Date:** April 5, 2004 (with April fiscal intermediary system quarterly release). **Pre-Implementation Contact(s):** Elizabeth Carmody, (410) 786-7533, or Cindy Murphy (410) 786-5733 **Post-Implementation Contact(s):** Appropriate Regional Office	**These instructions should be implemented within your current operating budget**