Medicare
Intermediary Manual
Part 3 - Claims Process

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

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THIS TRANSMITTAL MANUALIZES CHANGE REQUEST 817

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HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
3151.1 - 3152	3-59 - 3-60 (2 pp.)	3-59 - 3-60 (2 pp.)
3604 (Cont.) – 3604 (Cont.)	6-33 - 6-34 (2 pp.)	6-33 - 6-34 (2 pp.)
3604 (Cont.) – 3604 (Cont.)	6-57 - 6-58 (2 pp.)	6-57 - 6-58 (2 pp.)
3696.2 (Cont.) – 3696.2 (Cont.)	6-613 - 6-614 (2 pp.)	6-613 - 6-614 (2 pp.)
Addendum B (Cont.) – Addendum B (Cont.)	B-21 - B-22 (2 pp.)	B-21 - B-22 (2 pp.)

MANUALIZATION--*EFFECTIVE DATE: September 1997*
IMPLEMENTATION DATE: Not Applicable

The Medicare Intermediary Manual sections listed below are being updated to reflect the 30-month coordination period for individuals entitled to benefits on the basis of end stage renal disease who are covered by group health plans.

Section 3152, No Legal Obligation To Pay For Or Provide Services, updates the coordination periods to reflect the new 30-month coordination period.

Section 3604, Review Of Form HCFA-1450 For Inpatient And Outpatient Bills, updates the coordination periods to reflect the new 30-month coordination period.

Section 3696.2, MSP Maintenance Transaction Record Processing, updates the coordination periods to reflect the new 30-month coordination period.

Addendum B, Alphabetic Listing Of Data Elements, updates the coordination periods to reflect the new 30-month coordination period.

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.

General Exclusions From Coverage

3150. GENERAL EXCLUSIONS

No payment can be made under either the hospital insurance or supplementary medical insurance program for certain items and services.

A. Not reasonable and necessary (§3151);

B. No legal obligation to pay for or provide (§3152);

C. Paid for by a governmental entity (§3153);

D. Not provided within United States (§3154);

E. Resulting from war (§3155);

F. Personal comfort (§3156);

G. Routine services and appliances (§3157);

H. Excluded foot care services and supportive devices for feet (§3158);

I. Custodial care (§3159);

J. Cosmetic surgery (§3160);

K. Charges by immediate relatives or members of household (§3161).

L. Dental services (§3162)

M. Paid or expected to be paid under workers' compensation (§3163).

N. Nonphysician services provided to a hospital inpatient which were not provided directly or arranged for by the hospital (§3164).

3151. SERVICES NOT REASONABLE AND NECESSARY

Items and services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member are not covered.

3151.1 Devices Not Approved by FDA.--Medical devices which have not been approved for marketing by the FDA are considered investigational by Medicare and are not reasonable and necessary for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member. Program payment, therefore, may not be made for medical procedures or services performed using devices which have not been approved for marketing by FDA.

3152. NO LEGAL OBLIGATION TO PAY FOR OR PROVIDE SERVICES

Program payment may not be made for items or services which neither the beneficiary nor any other person or organization has a legal obligation to pay for or provide. This exclusion applies where items and services are furnished gratuitously without regard to the beneficiary's ability to pay and without expectation of payment from any source, such as free x-rays or immunizations provided by health organizations. However, Medicare reimbursement is not precluded merely because a provider, physician, or supplier waives the charge in the case of a particular patient or group or class of patients, as the waiver of charges for some patients does not impair the right to charge others, including Medicare patients. The determinative factor in applying this exclusion is the reason the particular individual is not charged.

The following sections illustrate the applicability of this exclusion to various situations involving services other than those paid for directly or indirectly by a governmental entity. (For a discussion of the latter, see § 3153.)

A. Indigency.--This exclusion does not apply where items and services are furnished an indigent individual without charge because of his inability to pay, if the provider, physician, or supplier bills other patients to the extent that they are able to pay.

B. Provider, Physician, or Supplier Bills Only Insured Patients.--Some providers, physicians, and suppliers waive their charges for individuals of limited means, but they also expect to be paid where the patient has insurance which covers the items or services they furnish. In such a situation, because it is clear that a patient would be charged if insured, a legal obligation to pay exists and benefits are payable for services rendered to patients with medical insurance if the provider, physician, or supplier customarily bills all insured patients--not just Medicare patients--even though non-insured patients are not charged.

Individuals with conditions which are the subject of a research project may receive treatment financed by a private research foundation. The foundation may establish its own clinic to study certain diseases or it may make grants to various other organizations. In most cases, the patient is not expected to pay for his treatment out-of-pocket, but if he has insurance, the parties expect that the insurer will pay for the services. In this situation, a legal obligation is considered to exist in the case of a Medicare patient even though other patients may not have insurance and are not charged.

C. Medicare Patient Has Other Health Coverage.--Except as provided in §§3419ff., 3490ff. and 3491ff., payment is not precluded under Medicare even though the patient is covered by another health insurance plan or program which is obligated to provide or pay for the same services. This plan may be the type which pays money toward the cost of the services, such as a health insurance policy, or it may be the type which organizes and maintains its own facilities and professional staff. Examples of this latter type are employer and union sponsored plans which furnish services to special groups of employees or retirees or to union members, and group practice prepayment plans.

The exceptions to this rule are services covered by automobile medical or no-fault insurance (§§3419ff.), services rendered during a specified period of up to 30 months to

Code	Structure
61	Discharged/transferred within this institution to a hospital-based Medicare approved swing bed
71	Discharged/transferred/referred to another institution for outpatient services as specified by the discharge plan of care
72	Discharged/transferred/referred to this institution for outpatient services as specified by the discharge plan of care

FL 23. Medical Record Number
Required. This is the number assigned to the patient's medical/health record by the provider. If the provider enters a number, you must carry the number through your system and return it to the provider.

FLs 24, 25, 26, 27, 28, 29, and 30. Condition Codes
Required. Code(s) identifying conditions related to this bill which may affect processing.

Code structure (only codes affecting Medicare payment/processing are shown).

Code	Title	Definition
02	Condition is Employment Related	Code indicates patient alleges that the medical condition in this episode of care is due to environment/events resulting from employment. (See §§3415.2ff. for WC and §§3415.3ff. for BL.)
04	Patient is HMO Enrollee	Code indicates bill is submitted for information only and the Medicare beneficiary is enrolled in a risk-based HMO and the hospital expects to receive payment from the HMO.
05	Lien Has Been Filed	Provider has filed legal claim for recovery of funds potentially due to a patient as a result of legal action initiated by or on behalf of a patient.
06	ESRD Patient in the First 30 Months of Entitlement Covered By Employer Group Health Insurance	Code indicates Medicare may be a secondary insurer if the patient is also covered by employer group health insurance during the first 30 months of end stage renal disease entitlement.
07	Treatment of Nonterminal Condition for Hospice	Code indicates the patient has elected hospice care but the provider is not treating the terminal condition, and is, therefore, requesting regular Medicare payment.
08	Beneficiary Would Not Provide Information Concerning Other Insurance Coverage	Code indicates the beneficiary would not provide information concerning other insurance coverage. Develop to determine the proper payer. (See §3686 for development guidelines.)
09	Neither Patient Nor Spouse is Employed	Code indicates that in response to development questions, the patient and spouse have denied employment.

Code	Title	Definition
10	Patient and/or Spouse is Employed but no EGHP Coverage Exists	Code indicates that in response to development questions, the patient and/or spouse indicated that one or both are employed but have no group health insurance from an EGHP or other employer sponsored or provided health insurance that covers the patient.
11	Disabled Beneficiary But no LGHP	Code indicates that in response to development questions, the disabled beneficiary and/or family member indicated that one or more are employed, but have no group coverage from an LGHP or provided health insurance that covers the patient.
12-14	Payer Codes	Codes reserved for internal use only by third party payers. HCFA will assign as needed for your use. Providers will not report them.
15	Clean Claim Delayed in HCFA's Processing System (Payer Only Code)	Code indicates that the claim is a clean claim in which payment was delayed due to a HCFA processing delay. Interest is applicable, but the claim is not subject to CPEP/CPT standards. (See §3600.1A.3.)
16	SNF Transition Exemption (Medicare Payer Only Code)	Code indicates an exemption from the post-hospital requirement applies for this SNF stay or the qualifying stay dates are more than 30 days prior to the admission date.
20	Beneficiary Requested Billing	Code indicates the provider realizes the services on this bill are at a noncovered level of care or otherwise excluded from coverage, but the beneficiary has requested a formal determination.
21	Billing for Denial Notice	Code indicates the provider realizes services are at a noncovered level of care or excluded, but requests a denial notice from Medicare in order to bill Medicaid or other insurers.
26	VA Eligible Patient Chooses to Receive Services in a Medicare Certified Facility	Code indicates patient is VA eligible and chooses to receive services in a Medicare certified facility instead of a VA facility.
27	Patient Referred to a Sole Community Hospital for a Diagnostic Laboratory Test	(Sole community hospitals only). Code indicates the patient was referred for a diagnostic laboratory test. Use to indicate laboratory service is paid at 62 percent fee schedule rather than 60 percent fee schedule.

Laboratory tests (revenue codes 300-319) are billed as net for outpatient or nonpatient bills because payment is based on the lower of charges for the hospital component or the fee schedule. Determine, in consultation with the provider, whether it must bill net or gross for each revenue center other than laboratory. Where "gross" billing is used, adjust interim payment rates to exclude payment for hospital-based physician services.

The physician component must be billed to the carrier to obtain payment.

FL 48. Non-Covered Charges
Required. The total noncovered charges pertaining to the related revenue code in FL 42 are entered here.

FL 49. (Untitled)
Not Required. This is one of the four fields which have not been assigned. Use of the field, if any, is assigned by the NUBC.

FLS 50A, B, C. Payer Identification
Required. If Medicare is the primary payer, "Medicare" is entered on line A. If Medicare is entered, the provider has developed for other insurance and has determined that Medicare is the primary payer. All additional entries across line A (FLs 51-55) supply information needed by the payer named in FL 50A. If Medicare is the secondary or tertiary payer, the provider identifies the primary payer on line A and enters Medicare information on lines B or C, as appropriate. (See §§3407-3415, §§3419, and §§3489-3492 to determine when Medicare is not the primary payer.)

FLs 51A, B, and C. Provider Number
Required. This is the six-digit number assigned by Medicare. It must be entered on the same line as "Medicare" in FL 50.

FLs 52A, B, and C. Release of Information
Required. A "Y" code indicates the provider has on file a signed statement permitting the provider to release data to other organizations in order to adjudicate the claim. An "R" code indicates the release is limited or restricted. An "N" code indicates no release on file.

FLs 53A, B, and C. Assignment of Benefits Certification Indicator
Not Required.

NOTE: The back of the HCFA-1450 contains a certification that all necessary release statements are on file.

FLs 54A, B, and C. Prior Payments
Required. For all services other than inpatient hospital and SNF services, the sum of any amount(s) collected by the provider from the patient toward deductibles (cash and blood) and/or coinsurance are entered on the patient (fourth/last) line of this column.

Part A home health DME cost sharing amounts collected from the patient are reported in this item. In apportioning payments between cash and blood deductibles, the first 3 pints of blood are treated as noncovered by Medicare. Thus, for example, if total inpatient hospital charges are $350 including $50 for a deductible pint of blood, $300 is to be apportioned to the Part A deductible and $50 to the blood deductible. Blood is treated the same way in both Part A and Part B.

FLs 55A, B, and C. Estimated Amount Due
Not Required.

FL 56 (Untitled)
Not Required. This is one of the seven fields which have not been assigned for national use. Use of the field, if any, is assigned by the SUBC and is uniform within a State.

FL 57. (Untitled)
Not Required. This is one of the seven fields which have not been assigned. Use of the field, if any, is assigned by the NUBC.

FLs 58A, B, and C. Insured's Name
Required. 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 provider enters the patient's name as shown on his HI card or other Medicare notice. All additional entries across that line (FLs 59-66) pertain to the person named in FL 58. The instructions which follow explain when those items are completed.

If there are payers of higher priority than Medicare and the provider is requesting payment because another payer paid some of the charges and Medicare is secondarily liable for the remainder, another payer denied the claim, or the provider is requesting a conditional payment as described in "3679K, 3680K, 3681K, or 3682K, it enters the name of the individual in whose name the insurance is carried. If that person is the patient, the provider enters "Patient." Payers of higher priority than Medicare include:

- EGHPs for employed beneficiaries and their spouses. (See §3491.);
- EGHPs for beneficiaries entitled to benefits solely on the basis of ESRD during a period up to 30 months. (See §3490.);
- LGHPs for disabled beneficiaries;
- Automobile medical, no-fault, or liability insurer. (See §§3419 and 3490.); or
- WC, including BL. (See §§3407-3416.)

FLs 59A, B, and C. Patient's Relationship to Insured
Required. If the provider is claiming a payment under any of the circumstances described in the second paragraph of FLs 58A, B, or C, it may enter the code indicating the relationship of the patient to the identified insured, if this information is readily available.

Code	Title	Definition
01	Patient is Insured	Self-explanatory
02	Spouse	Self-explanatory
03	Natural Child/Insured has Financial Responsibility	Self-explanatory
04	Natural Child/Insured does not have Financial Responsibility	Self-explanatory
05	Step Child	Self-explanatory
06	Foster Child	Self-explanatory
08	Employee	Patient is employed by the insured.

You may update any auxiliary occurrences. However, an auxiliary occurrence can only be deleted by the contractor who originated the record. A deleted record will still appear on the HIMR display with a 'D' and will only be removed via the purge process (see §3696.8), or when the 17 record maximum is reached. However, delete records are not used in MSP claim processing.

Before and after images of the changes to the MSP auxiliary occurrences are written to the MSP Audit File.

B. CWF MSP Auxiliary File.--A maximum number of 17 MSP auxiliary records may be stored in CWF for each beneficiary. Beginning with the 15th occurrence, a disposition code 15 will be reported on the reject file and you will receive a performance report for each occurrence added thereafter. The report will indicate that the maximum number of occurrences (17) is approaching. Review the report to determine which records should be deleted from the auxiliary file.

If the MSP auxiliary file already contains 17 occurrences and another occurrence is added, one of the 17 existing occurrences will be archived from the MSP auxiliary file to the MSP Audit File using the following priority:

- Oldest "deleted" (flagged for deletion) occurrence;
- Oldest "confirmed no" occurrence;
- Oldest termination date; or
- Oldest maintenance date for the MSP type to be added.

If none apply, a reject code will be received. Identify which record(s) should be deleted and take the necessary action to delete.

C. Integrity of MSP Data.--In the future it is envisioned that the CWF data base will contain an MSP auxiliary record with a validity indicator of 'N' or 'Y' for every beneficiary entitled to Medicare. These auxiliary records, for each beneficiary entitled to Medicare, will provide historical MSP data and eliminate improper Medicare payments.

The CWF MSP data base integrity is totally dependent upon you. You are responsible for submitting to CWF MSP information you believe to be of the highest quality. Investigate your information thoroughly before making changes to an existing MSP auxiliary record.

Update your internal MSP control file with the information received via the CWF '03' trailer response. If you have more current information that conflicts with that received from CWF, it is your responsibility to correct the CWF MSP auxiliary record via a CWF MSP maintenance transaction.

1. MSP Effective Date Change Procedure.--When you have evidence that the MSP effective date is incorrect and you have established the record (originating contractor):

- Delete the auxiliary record containing the incorrect MSP effective date using an MSP delete transaction; and

- Submit a CWF MSP maintenance transaction with the correct MSP effective date to establish a new auxiliary record.

NOTE: When the beneficiary is entitled to both Part A and B, use the Part A entitlement date, if the insurance effective date is prior to entitlement to Medicare.

2. CWF/MSP Transaction Request for Contractor Assistance.--If another contractor established the auxiliary record:

o Request the originating contractor, using CWF MSP Assistance Request, Exhibit 1, to change the MSP effective date using the procedures described above. Submit documentation to substantiate the change to the assisting contractor.

o Make certain you cannot change the record before preparing a CWF MSP Assistance Request. The only two actions you cannot take if you are not the originating contractor are: Alter an MSP effective date, or delete a record that was established by another contractor. You have the ability to change all other fields.

o Allow 15 days for the contractor to respond to your request. After 15 days, telephone the contractor MSP contact to determine the reason for delay.

o Notify your RO if a contractor consistently has problems responding to your requests.

3. MSP Termination Date Procedure.--CWF will allow future termination dates of:

o Up to 6-months for all MSP types, except ESRD. For ESRD, CWF use the following criteria:

-- MSP effective date prior to 2/1/90, allows for termination date up to 12-months after the effective date.

-- MSP effective date 2/1/90 through 2/29/96 allows for termination date up to 18 months after the effective date.

-- MSP effective date 3/1/96 or later allows for a termination date up to 30 months after the effective date.

A termination date can only be added (not changed) to MSP auxiliary records established by contractor number "77777." A termination date can only be added (not changed) to MSP auxiliary records established by contractor numbers "11101-11106."

A CWF MSP auxiliary record with a 'Y' validity indicator indicates Medicare as the secondary payer. When posting a termination date to this record the 'Y' validity indicator should not be changed. The record indicates a valid MSP occurrence and all future claims submitted will edit against the timeframe posted. Enter the termination date whenever the MSP situation no longer applies.

A CWF MSP auxiliary record with an 'N' validity indicator indicates Medicare is the primary payer. The MSP effective and MSP termination dates on the 'N' record should be the same. All records with an 'N' validity indicator should contain both an MSP effective and termination date.

3696.3 MSP Claim Processing.--When a CWF Part A bill is submitted, CWF performs consistency edit checks. Refer to CWF Systems Documentation, Record Name: CWF Inpatient/SNF Bill Record for the complete record layout and field descriptions. MSP claims failing the consistency edits will receive a reject with the appropriate disposition code, reject code and MSP trailer data. Refer to CWF Systems Documentation, Record Name: CWF MSP Basic Reply Trailer Data for the complete record layout and field descriptions. Claims passing the consistency edit process are reviewed for utilization compliance. Claims rejected by the utilization review process are rejected with the appropriate disposition code, reject code and MSP trailer data.

Data Element	Definition	Record	Field
Payer Address	Complete mailing address for the payer A organization from which the provider might expect some payment for the bill. Reiterates in sequences 02 and 03 for payers B and C.	32	5-9
	Address	32	5
	Address	32	6
	City	32	7
	State	32	8
	Zip Code	32	9
Payer Code	Identifies reason another payer is primary to Medicare. Z = Medicare is primary A = Working Aged None/Spouse with EGHP B = ESRD beneficiary in 30 month period with EGHP C = Any conditional payment situation D = Automobile no-fault or any liability insurance E = Workers Compensation F = PHS, other federal agency G = Disabled beneficiary under age 65 with LGHP H = Black Lung I = Veterans Administration (VA)	30	9
Payer Identification	Identifier designating the payer A organization from which the provider might expect some payment for the bill. Reiterates in sequences 02 and 03 for Payers B and C. This combines the formerly separate fields 5 (Payer Identification) and 6 (Payer Sub-identification). Non-Medicare payers may use the first five positions for the payer organization and the remaining four positions describe the specific office within the insurance carrier designated as responsible for this claim.	30	5-6
Payer Identification Indicator	Code indicating if the HCFA PAYER ID is being used in RT 30, fields 5-6. XV = HCFA Payer ID (2 spaces) = non-HCFA payer code.	30	8a
Payer Name	Name identifying each payer organization from which the provider might expect some payment for the bill.	30 32	8b 4
Payments Received	Amount patient has paid to the provider towards this bill.	20 30	23 25

Data Element	Definition	Record	Field
Physical Record Count (Excluding Screen)	The total number of physical records submitted for this bill, including all RTs 20 through 8n, and excluding RT 90.	90	4
Physician Number Qualifying Codes	The type of physician number being submitted. UP = UPIN FI = Federal Taxpayer ID Number SL = State License ID Number SP = Specialty License Number XX = National Provider Identifier (NPI)	80	4
Physician Referral Date (CCYYMMDD)	Date physician referred the patient for evaluation and treatment.	77-A	7
Physician Signature Date on Plan of Treatment (CCYYMMDD)	Indicates the date of written physician verification and/or certification of the plan of treatment for outpatient rehabilitative services.	77-A	9
Physician's Zip Code	The nine-digit ZIP code from the address field on Form HCFA-485.	71	23
Pick-up Address	Address where the ambulance pick-up was made, e.g., patient's home, hospital, scene of accident	75-01	17-20
	Place 75-01	17	
	City	75-01	18
	State 75-01	19	
	Zip Code	75-01	20
Pick-up Destination Code	Code describing pickup and destination points. For use where there is no applicable HCPCS modifier that can be reported on RT 61 or the modifier is less descriptive than the code below. Use one code for the originating trip (in field 8) and one for the return trip (in field 9). D01 = Nursing home to ESRD facility D02 = Hospital to ESRD facility D03 = ESRD facility to nursing home or hospital D04 = Transfer from hospital to air ambulance pickup site D05 = Transfer from air ambulance landing site to hospital	75-01	8-9

* Not required for Medicare