After a provider has made the decision to participate in the Medicare Program and has completed the enrollment process, the next decision involves determining how to submit claims for payment. This section of the guide introduces providers to the general rules regarding the claims submission process.

It is helpful for providers to have a thorough understanding of the claims process before submitting claims to Medicare. Providers will need to know when it is appropriate to submit claims electronically or on paper, what claim forms to use, and what, if any, additional documentation to submit. In addition, consideration must be made regarding whether Medicare should be billed as a primary or secondary insurer, and what documentation is required when the beneficiary is going to lose benefit coverage under Medicare.

**Accuracy of Beneficiary Information**

Failure to record the beneficiary’s name and identification number on a claim exactly as they appear on the Medicare Health Insurance card may result in a payment rejection or claim delay.

**HOW DOES A PROVIDER SUBMIT A MEDICARE PART B CLAIM?**

Submission of a Medicare claim, whether submitted electronically or on paper, is the only way a provider or beneficiary can receive reimbursement from Medicare. If there are discrepancies on a claim form, the beneficiary may not receive full benefits.

Medicare Part B provider claims are submitted by providers to their local Medicare Contractor [Carrier, Durable Medical Equipment Regional Contractor (DMERC), or Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC)] using Form CMS-1500. See Reference B for copies of the Form CMS-1500 templates and instructions for completion.

On January 6, 2006, the Centers for Medicare & Medicaid Services (CMS) awarded the DME MAC contracts. These contracts are for the administration of Medicare claims from suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS). DMERCs are currently in the process of being transitioned into DME MACs. DME suppliers currently enrolled in the Medicare fee-for-service program do not have to re-enroll or obtain a new supplier number. Please refer to Reference F of this guide for DMERC/DME MAC contact information.
Form CMS-1500 Claim Form Information

Providers can download copies of the claim form at [www.cms.hhs.gov/CMSForms/CMSForms/list.asp](http://www.cms.hhs.gov/CMSForms/CMSForms/list.asp) on the CMS website.

Official red-printed Form CMS-1500s are available for purchase from various vendors. They are also available in various formats from the United States Government Printing Office (GPO). Negatives are also available from the GPO. Contact the GPO at 1-866-512-1800 or mail publication order inquiries to:

Superintendent of Documents
P.O. Box 371954
Pittsburgh, Pennsylvania 15250-7954

Providers can also contact the GPO for printing information at [http://bookstore.gpo.gov](http://bookstore.gpo.gov) on the Web.

Claim form **CMS-1500 (12-90)** is being revised to accommodate the reporting of the National Provider Identifier (NPI) and will then be named **CMS-1500 (08-05)**. The following timeline outlines the schedule for using the revised CMS-1500 claim form:

- January 2, 2007: Health plans, clearinghouses, and other information support vendors shall be ready to handle and accept the revised Form CMS-1500 (08/05).
- January 2, 2007 - March 30, 2007: Providers can use either the current Form CMS-1500 (12/90) version or the revised Form CMS-1500 (08/05) version.
- April 2, 2007: The current Form CMS-1500 (12/90) version of the claim form is discontinued; only the revised Form CMS-1500 (08/05) is to be used. All rebilling of claims should use the revised Form CMS-1500 (08/05) from this date forward, even though earlier submissions may have been on the current Form CMS-1500 (12/90).

Claims can be submitted in one of the following ways:

- Using Electronic Media Claims (EMCs) submitted from the provider’s office
- Using a paper claim

**Note:** A provider may submit EMCs or paper claims directly to a Medicare Contractor or use a third-party billing service who will submit the claims to the Medicare Contractor on the provider’s behalf.

**Health Insurance Portability and Accountability Act of 1996 (HIPAA) Compliance Mandated**

As of October 1, 2005, providers who submit electronic claims must be in compliance with HIPAA format.

**SUBMITTING CLAIMS ELECTRONICALLY**

Medicare issues a sender number to a provider electronically submitting Medicare claims. These EMCs are transmitted from the provider’s computer to the Medicare Contractor in accordance with HIPAA’s electronic filing standards. For additional information regarding HIPAA transaction standards, refer to Section 8 of this guide.

The EMC submission process eliminates the need for mailroom processing, thereby improving the timeliness of claims. The system also releases claims payments when CMS time frame requirements are satisfied, resulting in a faster payment turnaround for providers. Generally, correctly filed HIPAA-compliant electronic claims...
can be paid 14 days after the Medicare Contractor receives the transmission, as opposed to paper claims that process in about 4 weeks. Payment for paper claims must be held for 29 days (see Figure 3-1).

![Figure 3-1. Payment Schedule for Electronic and Paper Claims.](image)

When a provider submits electronically, he or she will receive immediate notification that the Medicare Contractor has received the Medicare claim. Medicare Contractors also have systems that provide notification of critical claim filing errors, allowing providers to correct a claim before it enters the Medicare processing system. This eliminates receiving a denial or having to wait for the claim to be returned for correction. Providers can immediately correct front-end edits and retransmit them without waiting a day.

**HOW ELECTRONIC MEDIA CLAIM (EMC) SUBMISSION WORKS**

The provider electronically transmits the claim via modem wire transmission to the Medicare Contractor’s computer using the Internet. The Medicare Contractor will use the Multiple Carrier System (MCS) to process the claims data and transmit it to another system, where it is electronically checked (“edited”) for required information. Claims that pass these initial edits, commonly known as *front-end edits* or *pre-edits*, are then processed according to Medicare policy and guidelines. Claims with inadequate or incorrect information do **NOT** pass the initial edits. Instead, the claims are rejected and are not paid, or the claims are returned to the provider. Rejecting and returning the claim to the provider are two separate functions within the process. If the claim is labeled by MCS as a “reject” the claim is denied. If the claim is labeled by MCS as a “Return To Provider” (RTP), the claim is returned to the provider for correction and resubmission. Refer to Section 6 of this guide for information that will help troubleshoot an unsuccessful transmission.

After a successful transmission, a confirmation report or acknowledgement report is generated and is either transmitted back to the provider or placed in an electronic mailbox for the provider to download. The provider should immediately and carefully review this report. The report indicates the number of claims accepted and the total dollar amount transmitted. However, this report will also list the claims that were rejected, as well as the reason(s) for being rejected, unless the claim was denied due to medical necessity. If a claim was denied due to medical necessity, the provider cannot correct and re-bill the claim, and instead must appeal the rejection (see Section 7 of this guide for appeals information). Otherwise, the provider can make the necessary correction(s) to the rejected claim(s) and resubmit the corrected claim(s) immediately.
Development Letters/Record Requests

Occasionally, claims require additional information before they can be completed. A development letter requesting the missing information is sent to the provider and/or beneficiary. When the information is received, the claim is processed for payment consideration. Failure to respond to a request for additional development may result in denial of a provider’s claim.

Development letters may be sent to providers because of a focused Medical Review (MR), or because CMS has requested that a certain percentage of claims be reviewed by the Medicare Contractor for various reasons.

Office of Management and Budget (OMB) Collection Number

All Additional Documentation Requests (ADRs) or any other written request for additional documentation for MR audit purposes must contain the collection number “OMB#: 0938-0969” or “OMB Control #: 0938-0969” in the header, footer, or body of the document.

Certificate of Medical Necessity (CMN)

Providers who submit claims electronically gain access to additional functions such as CMNs. For certain items or services, the supplier must receive a signed CMN from the treating physician. CMNs may be used when submitting claims for certain DME and oxygen services.

When CMNs are submitted electronically to the Medicare Contractor for DME, only information in Sections A, B, and D of the CMN are required since the information in Section C cannot be transmitted electronically. However, suppliers who bill electronically are not exempt from completing Section C of the original CMN. Please refer to Chapter 5, Section 5.3.3, of the Medicare Program Integrity Manual, which is available at www.cms.hhs.gov/Manuals/IOM/list.asp on the CMS website. The DMERC/DME MAC should also be able to provide additional information regarding completion of CMNs.

Note: CMNs are not necessary for every claim and, if necessary, are not always required with the initial claim submission. The DMERC/DME MAC can provide additional information.

The following are alternatives for electronically submitting claims data:

- Providers may work through a software vendor who can provide the level of practice management system support needed for the provider’s practice setting.
- Providers may submit their Medicare claims directly to the Medicare Contractor or choose to submit claims through a clearinghouse.
- Providers may choose to have a billing agent handle all or part of the Medicare billing.
- If the provider’s office has the required hardware, the office may choose to use Medicare’s free billing software.

HOW TO APPLY FOR ELECTRONIC MEDIA CLAIM (EMC) SUBMISSION

To submit an EMC using the Electronic Data Interchange (EDI) in HIPAA format, the provider or supplier must complete and submit the Standard Electronic Data Exchange Enrollment Form to their local Medicare Contractor prior to submitting the EMC to Medicare for payment. Providers must also complete and submit the Authorization Agreement for Electronic Funds Transfer (EFT) and submit it to their local Medicare Contractor.
In addition to the day-to-day benefits of EMC, the following features are also available to electronic filers:

- **Eligibility Access**: Participating providers who file claims electronically may acquire access to beneficiary eligibility files through their vendor. The provider can determine if a patient is eligible for Medicare benefits, has met the Medicare deductible, is enrolled in a Health Maintenance Organization (HMO), or is entitled to Medicare when Medicare is the secondary payer.

- **Electronic Remittance Advice (ERA)**: A provider can receive notice of paid, adjusted, or denied claims information electronically from MCS. There are many advantages to receiving the ERA electronically including faster communication and payment notification. The ERA may be used to automatically update provider accounts receivable files or the patient billing system.

- **Electronic Claims Status (ECS)**: EMC providers may obtain a paper or electronic list of all Medicare pending claims 14 days or older for tracking and monitoring.

- **Electronic Funds Transfer (EFT)**: With EFT, payments can be sent directly to a provider’s financial institution whether claims are filed through EMC or on paper.

An organization comprised of multiple components that have been assigned more than one Medicare provider number may elect to execute a single EDI Enrollment Form on behalf of the organizational components to which these numbers have been assigned. The organization as a whole is then responsible for submitting claims for each of its facilities.

### CMS Enrollment and Electronic Data Interchange (EDI) Forms

Additional information regarding the Medicare Federal Health Care Provider/Supplier Enrollment Application is available in Portable Document Format (PDF file) at [www.cms.hhs.gov/MedicareProviderSupEnroll/](http://www.cms.hhs.gov/MedicareProviderSupEnroll/) on the CMS website.

#### General EDI Enrollment Information


#### Local Carrier Help Lines


**SUBMITTING PAPER CLAIMS**

Today, only a limited number of qualified providers are permitted to submit paper claims. Per HIPAA mandates established as of October 16, 2003, to submit a paper Medicare claim a provider must be one of the following:

- Small provider (institutional organizations with 25 or less full-time employees or physicians and suppliers with 10 or less full-time employees)
- Dentist
Participant in a Medicare demonstration project in which paper claim filing is required due to the inability of the Applicable Implementation Guide that was adopted under HIPAA to report data essential for the demonstration

Provider that conducts mass immunizations (e.g., flu injections) and may be permitted to submit paper roster bill

Provider that submits claims when more than one other payer is responsible for payment prior to Medicare payment

Provider that only furnishes services outside of the United States

Provider experiencing a disruption in electricity and communication connections that are beyond its control

Provider that can establish that an “unusual circumstance” exists which precludes electronic claim submission

Unlike HIPAA-compliant EMC claims that can be paid within 14 days, paper claims cannot be paid until 29 days after the Medicare Contractor has received a “clean” (i.e., error-free) claim.

Providers may never charge Medicare patients for completing or filing a claim. Proper completion and submission of a “clean” (i.e., error-free) Medicare claim is the first step in accurate claims processing. Clean claims are claims that successfully process without system-generated requests for additional or corrected information and contain no date entry errors. Before submitting paper claims, qualified providers should contact their Medicare Contractor to identify the most effective options for submitting such claims.

**Note:** When submitting a claim to Medicare when Medicare is the secondary payer, the claims must be submitted in hard copy to the Medicare Contractor. Refer to Section 3, Submitting Medicare Secondary Payer (MSP) Claims, of this guide for Medicare Secondary Payer (MSP) guidelines.

### Submitting a “Black and White” Form CMS-1500

There are some Medicare Contractors who accept “black and white” copies of Form CMS-1500, and copies containing handwritten instead of typed entries. If a Medicare Contractor does accept such a form, the provider may not be required to submit the back side of the form if a signed attestation statement is filed with the Medicare Contractor on an annual basis. This statement should say, “…he or she has read the reverse side of Form CMS-1500 and understands the requirements and agrees to comply with applicable Medicare billing requirements.” These options vary by Medicare Contractor.

### HOW PAPER CLAIM SUBMISSION WORKS

The majority of paper claims sent to Medicare Contractors are scanned using Optical Character Recognition (OCR) technology. This scanning technology allows for the data contents contained on the form to be scanned. This automated scanning process is similar to scanners that read price labels in grocery stores. However, to work properly, OCR must accurately read and interpret the characters entered in each field. It reads only typed or machine-printed data. If a Medicare Contractor uses OCR software for automated claims processing, only an original, red and white Form CMS-1500 may be submitted.

After the claims information is scanned, it is transmitted to the claims processing system where it is validated and compared to other data until final processing occurs.

To ensure accurate, quick claim processing, the following guidelines should be followed:

- Do not staple, clip, or tape anything to the Form CMS-1500 claim form.
- Place all necessary documentation in the envelope with the Form CMS-1500 claim form.
Put the patient’s name and Medicare number on each piece of documentation submitted.

Use dark ink.

Use only upper-case (CAPITAL) letters.

Use 10- or 12-pitch (pica) characters and standard dot matrix fonts.

Do not use italics or script.

Avoid using old or worn print bands or ribbons.

Do not use dollar signs, decimals, or punctuation.

Enter all information on the same horizontal plane within the designated field.

Do not print, hand-write, or stamp any extraneous data on the form.

Use only lift-off correction tape to make corrections.

Ensure data is in the appropriate field and does not overlap into other fields.

Remove pin-fed edges at side perforations.

Use only an original red-ink-on-white-paper Form CMS-1500 claim form.

ARE THERE ANY SPECIAL CONSIDERATIONS WHEN SUBMITTING CLAIMS?

Depending on the specialty of the provider, there are special considerations a biller must be aware of when submitting claims. These considerations include the following:

- Deciding to accept assignment
- Determining whether claims should be submitted to Medicare
- Submitting Certificates of Medical Necessity (CMNs)
- Providing Advance Beneficiary Notices (ABNs)

- Notices of Exclusions from Medicare Benefits (NEMBs)
- Deciding what additional documentation to submit with the initial claim if the Medicare Contractor requests additional information

ACCEPTING OR NOT ACCEPTING ASSIGNMENT

Certain Part B providers must always accept Medicare payments while other physicians, practitioners, and suppliers may choose to enter into a participating agreement. Parts B “participating providers” are paid at 100% of the Medicare Physician Fee Schedule (MPFS) and must accept assignment. This means that they must accept Medicare payment as payment in full, except for any unmet deductible and coinsurance that would be the patient’s responsibility. However, this does not apply to claims billed to the Durable Medical Equipment Regional Carriers (DMERCs)/DME Medicare Administrative Contractors (DME MACs).

However, Part B “non-participating providers” are paid at 95% of the Fee Schedule (less deductible and coinsurance) and may accept assignment on a claim-by-claim basis. Beneficiary liability for coinsurance of non-participating providers varies by type of provider service, and the provider may be subject to a limiting charge. However, this does not apply to claims billed to the DMERCs/DME MACs. Also, regardless of participation, some suppliers and practitioner types are required to accept assignment.

All physicians and suppliers are required to file claims with Medicare Contractors on behalf of all beneficiaries within one year from the date of service per the Omnibus Budget Reconciliation Act (OBRA) of 1989. Regardless of the type of claim, providers may never charge Medicare patients for completing or filing a claim. Proper completion and submission of a “clean” (i.e., error-free) Medicare claim is the first step in accurate claims processing. Clean claims are claims that successfully process without system-generated requests for additional information.
SUBMITTING ASSIGNED CLAIMS

Either a participating or a non-participating Part B provider may file assigned claims for any Part B claim. The provider is held to the assignment agreement for that claim only and agrees to accept the Medicare Fee Schedule amount as payment in full for all covered services. The provider is reimbursed directly. To accept assignment of Medicare benefits for a claim, the Part B provider must check “Yes” in Form Locator (FL)/Block 27 on Form CMS-1500 (see Figure 3-2). Providers may collect reimbursement for excluded services, unmet deductible(s), and coinsurance amounts from the beneficiary.

Figure 3-2. Check “Yes” to Accept Assignment

Assignment is mandatory for the following claims:

- Clinical diagnostic laboratory services and physician laboratory services
- Physician services to individuals dually entitled to Medicare and Medicaid
- Services of Physician Assistants (PAs), Advanced Registered Nurse Practitioners (ARNPs), Clinical Nurse Specialists (CNSs), nurse midwives, Certified Registered Nurse Anesthetists (CRNAs), clinical psychologists, clinical social workers, and medical nutritional therapists
- Ambulatory Surgical Center (ASC) services
- Home dialysis supplies and equipment paid under Method II
- Drugs
- Ambulance services

For practitioner services of physicians, and services of independently practicing physical and occupational therapists, the acceptance of assignment is not mandatory. Acceptance of assignment is also not mandatory for suppliers of radiology services or diagnostic tests. However, these practitioners and suppliers may voluntarily agree to participate in taking advantage of the higher payment rate, in which case the participation status makes assignment mandatory for the term of the agreement.

SUBMITTING NON-ASSIGNED CLAIMS

Only a non-participating provider may file non-assigned claims. A non-participating provider does not agree to accept Medicare’s allowed amount as payment in full and may charge the beneficiary or the service(s) up to the limiting charge. The limiting charge is the maximum amount that a non-participating provider may charge the beneficiary.

The limiting charge applies to all of the following services/supplies, regardless of who provides or bills for them:

- Physicians’ services
- Services and supplies furnished incidental to physician’s services that are commonly furnished in a physician’s office
- Outpatient physical and occupational therapy services furnished by an independently practicing therapist
- Diagnostic tests
- Radiation therapy service, including X-ray, radium, and radioactive isotope therapy, materials, and technician services

The limiting charge is 115% of the Fee Schedule amount.
Example of a Limiting Charge

Medicare Fee Schedule allowed amount = $200.00

Non-participating provider allowed amount = $190.00 (95% of $200)

Limiting charge = $218.50 ($190 x 1.15)

Maximum beneficiary coinsurance to non-participating provider = $28.50 ($218.50 - $190.00)

Note: This does not apply to claims billed to the DMERCs/DME MACs.

Note: The limiting charge provision does not apply to certain equipment and supplies. Please contact the Medicare Contractor for details. Limiting charge provisions also do not apply when Medicare is secondary to another insurance. A non-participating provider may round the limiting charge to the nearest dollar if done so consistently for all services.

When a non-participating provider files a Part B non-assigned claim, the beneficiary is reimbursed directly. To refuse assignment of Medicare benefits for a claim, the provider must check “No” in FL/Block 27 on Form CMS-1500 (see Figure 3-3).

SUBMITTING MEDICARE SECONDARY PAYER (MSP) CLAIMS

MSP is the term used when Medicare is not responsible for making the primary payment on beneficiary health care claims. All health care providers are required to determine, prior to submitting claims, whether Medicare is the primary or secondary payer. Medicare becomes the secondary payer when other primary insurance exists. The MSP provisions ensure that Medicare will make primary payment for claims when Medicare has primary payment responsibility for health care services provided to a Medicare beneficiary. However, Title XVIII, Section 1862(b) of the Social Security Act specifies that, under certain conditions, private insurance companies must make payment for services rendered to a Medicare beneficiary when the beneficiary carries a primary private insurance policy before Medicare will make payment. Recovery actions from other insurers are undertaken when Medicare primary payment errors are identified.

Medicare makes secondary payment for conditions when Medicare beneficiaries:

- Are covered under Group Health Plans (GHPs)
- Are covered under GHPs for those with End Stage Renal Disease (ESRD)
- Are covered under the Consolidated Omnibus Budget Reconciliation Act (COBRA) for those with ESRD
- Have been in an accident involving no fault or liability insurance
- Are covered under Workers’ Compensation (WC)
- Are covered under Veterans Health Administration (VHA) benefits
- Are covered under the Federal Black Lung Program for those with black lung disease.

Figure 3-3. Check “No” to Refuse Assignment
Providers should obtain billing information prior to providing services to Medicare beneficiaries. It is recommended that providers request that beneficiaries complete the Centers for Medicare & Medicaid Services (CMS) Secondary Claim Development (SCD) questionnaire or a questionnaire from which billing information can be obtained. Providers should submit any MSP information, including the SCD questionnaire and Explanation of Benefits (EOB), to the Medicare Contractor, including Condition Codes and Occurrence Codes. Sample SCD questionnaires can be viewed at www.cms.hhs.gov/InsurerServices/04_medicaresecclaimdevquest.asp on the CMS website.

MEDICARE SECONDARY PAYER (MSP) PROVISIONS

Until 1980, the Medicare Program was the primary payer in all situations except those involving Workers’ Compensation (WC) benefits. Since 1980, changes in Medicare law have resulted in Medicare being the secondary payer in other situations. The MSP provisions protect Medicare funds and ensure that Medicare does not pay for services reimbursable under private insurance plans or other government programs. Medicare may not pay if payment has been made, or can be reasonably expected to be made, with respect to an item or service that is covered under other health insurance or coverage.

MEDICARE COORDINATION OF BENEFITS (COB) CONTRACT

The purpose of the COB program is to identify health benefits available to a Medicare beneficiary and to coordinate the payment process to prevent and minimize overpayments of Medicare benefits. Information on eligibility and benefits entitlement is obtained from the COB central file and is used to facilitate accurate payment.

The COB program provides many benefits for employers, providers, physicians, suppliers, third-party payers, attorneys, beneficiaries, and federal and state programs. All MSP claim investigations are initiated and researched by the COB contractor, not by the local Medicare Contractor. This one-step approach minimizes the number of duplicate MSP investigations. It offers a centralized, one-stop customer service approach for all MSP-related inquiries, including those on general MSP information (but not related to specific claims or recoveries that serve to protect the Medicare Trust Fund). The COB contractor provides customer service to all callers from any source, including but not limited to beneficiaries, attorneys, other beneficiary representatives, employers, insurers, providers, physicians, suppliers, and other health plans.

Various methods and programs are used by the COB contractor to identify situations in which Medicare beneficiaries have other health insurance that is primary to Medicare. Medicare Contractors will continue to process claims submitted for primary or secondary payment. Claim processing is not a function of the COB contractor.

Medicare Secondary Payer (MSP) Inquiries

Refer all MSP inquiries to the COB contractor at 1-800-999-1118. TTY/TDD users should call 1-800-318-8782. Contact the local Medicare Contractor regarding claims and/or recovery-related questions.

Note: All possible insurers must be identified. There may be situations in which more than one insurer is primary to Medicare [e.g., liability or no-fault insurer, GHP].
BENEFITS OF THE MEDICARE SECONDARY PAYER (MSP) PROVISIONS

The successful implementation of the MSP provisions has resulted in positive benefits for Medicare, providers, suppliers, and the patient. Benefits include the following:

- **National program savings** - claims are paid by insurers that are primary to Medicare, resulting in a national program savings in excess of $4.5 billion dollars annually.

- **Increased revenue** - a provider or supplier that bills a liability insurer is entitled to pursue full charges. Receiving more favorable reimbursement is to the advantage of the provider or supplier. In many instances, insurance companies that are primary will pay the entire amount billed, rather than only the amount authorized under Medicare.

- **Lower out-of-pocket expenses** - multiple insurance coverages often reduces the amount a patient is obligated to pay, which includes satisfying deductible amounts and preserving Medicare coverage limits.

WHEN MEDICARE IS CONSIDERED SECONDARY

The MSP provisions make Medicare the secondary payer to insurance plans and programs under certain conditions. Three of the MSP provisions that require Medicare to be secondary payer related to GHPs are working aged, ESRD, and disability. Other provisions of the MSP provisions require Medicare to be secondary payer relating to disease or accidents as a result of employment or coverage available under Workers' Compensation (WC), liability, or no-fault insurance.

In addition, services authorized under the Veterans Health Administration (VHA) and other government programs are primary to Medicare even though they are not specific MSP provisions.

A brief description of situations in which MSP billing applies follows:

- **Services Payable Under GHP Benefits**

  **Working Aged** - Medicare benefits are secondary to benefits payable under a GHP for individuals age 65 or over who have GHP coverage as a result of their own current employment status or the current employment status of a spouse of any age. Specific conditions where this applies include:

  - MSP requires employers of 20 or more employees to offer their “working aged” employees and their spouses age 65 and over the same GHP offered to other employees.
  - Medicare is the secondary payer to a GHP when a single employer with 20 or more employees (as determined by the IRS) sponsors or contributes to the GHP, or when multiple employers sponsor or contribute to the GHP and at least one of them has 20 or more employees.

  **ESRD** - Medicare benefits are secondary to benefits payable under a GHP for individuals under age 65 who are eligible for, or entitled to, Medicare based on ESRD. This condition applies when individuals with ESRD who can receive secondary Medicare are beneficiaries also covered by a GHP or are beneficiaries who are covered family members of someone who is covered by a GHP. The Medicare coordination period for ESRD is described in Table 3-1.
<table>
<thead>
<tr>
<th>Stage</th>
<th>Timeframe</th>
<th>What Happens:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stage 1</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waiting Period for Eligibility</td>
<td>3 months from the first day of dialysis.</td>
<td>If GHP coverage is available, the GHP is primary and there is no Medicare coverage during the waiting period.</td>
</tr>
<tr>
<td><strong>Stage 2</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coordination Period</td>
<td>Begins with eligibility/entitlement for Medicare based on ESRD.</td>
<td>GHP is primary and Medicare is secondary.</td>
</tr>
<tr>
<td></td>
<td>For eligibility/entitlement beginning prior to 3/1/96, Coordination Period lasts 18 months.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>For eligibility/entitlement periods beginning on or after 3/1/96,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Coordination Period lasts 30 months.</td>
<td></td>
</tr>
<tr>
<td><strong>Stage 3</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Medicare Benefits</td>
<td>After Coordination Period, and until Stage 4 occurs.</td>
<td>Medicare is primary and GHP is secondary.</td>
</tr>
<tr>
<td><strong>Stage 4</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>End of Medicare Benefit</td>
<td>When patient has ceased dialysis treatments for 12 months.</td>
<td>Only GHP coverage is available.</td>
</tr>
<tr>
<td></td>
<td>OR</td>
<td></td>
</tr>
<tr>
<td></td>
<td>36 months after successful kidney transplant.</td>
<td></td>
</tr>
</tbody>
</table>

Table 3-1. Stages of End-Stage Renal Disease Coverage (ESRD) Under a Group Health Plan (GHP)

**End Stage Renal Disease (ESRD) Information**

Medicare entitlement can start earlier in some cases where the beneficiary received a kidney transplant, or is taking part in a home dialysis training program and expects to complete the training period within the first 3 months of dialysis. There is a separate coordination period each time a beneficiary becomes eligible for Medicare based on kidney failure. Entitlement can be resumed without a waiting period. For additional information, see the publication entitled *Medicare Coverage of Kidney Dialysis and Kidney Transplant Services* available at [www.medicare.gov/Publications/Pubs/pdf/10128.pdf](http://www.medicare.gov/Publications/Pubs/pdf/10128.pdf) on the Web.

If a GHP does not pay the entire charge for items or services furnished to a beneficiary, Medicare will make secondary payments, taking into account:

- The amount the GHP has allowed
- The amount Medicare considers reasonable for those items or services

If the GHP provides no benefits at all for particular medically necessary services (e.g., a kidney transplant), Medicare may pay for those services as primary payer, assuming the services are covered under Medicare.
Disabled Beneficiaries Covered Under a Large Group Health Plan (LGHP) - Medicare benefits are secondary to benefits provided by GHPs for certain disabled individuals under age 65 who have coverage based on their own current employment status or the current employment status of a family member. This applies when an individual who can receive secondary Medicare due to disability is a disabled beneficiary covered by an LGHP (100 or more employees), or the beneficiary is a family member of someone who is covered by an LGHP.

Services Related to Liability or No-Fault Insurance Coverage or Employment Related Disease or Accidents - Medicare is secondary payer to WC plans (including Federal Black Lung benefit programs). Payment under Medicare may not be made for any items or services if payment has been made, or can reasonably be expected to be made under a WC law or plan. If services are furnished that are not payable by WC, then Medicare is primary payer for those services.

Other Services Where MSP Provisions Apply

Veterans Health Administration (VHA) - The VHA pays for health care services rendered (usually at VHA facilities) to individuals who have served in the armed forces. When the VHA is unable to provide services at one of its facilities, the administration may authorize non-federal providers and suppliers to do so at federal expense. When VHA authorized items or services are provided at a non-federal facility, Medicare does not make payment for such items or services. Details about the VHA payment policy are provided within the Medicare Benefit Policy Manual, Chapter 16, Section 50.1.1, which is available at [www.cms.hhs.gov/Manuals/IOM/list.asp](http://www.cms.hhs.gov/Manuals/IOM/list.asp) on the CMS website. Search for publication #100-02.

Changes in Medicare Secondary Payer (MSP) Eligibility and Coverage

Eligibility coverage may change during a course of treatment. Providers and suppliers are required to query Medicare patients to determine if any of these MSP conditions apply.

Table 3-2 lists some common situations when Medicare is the primary and secondary payer.
<table>
<thead>
<tr>
<th>If the patient...</th>
<th>And this condition exist...</th>
<th>Then this program pays first...</th>
<th>And this program pays second...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is age 65 or older, and is covered by a General Health Plan (GHP) through a current employer...</td>
<td>The employer has less than 20 employees...</td>
<td>Medicare</td>
<td>GHP</td>
</tr>
<tr>
<td></td>
<td>The employer has 20 or more employees or at least one employer is a multi-employer group that employs 20 or more individuals...</td>
<td>GHP</td>
<td>Medicare</td>
</tr>
<tr>
<td>Has an employer retirement plan and is age 65 or older, or disabled and age 65 or older...</td>
<td>The patient is entitled to Medicare...</td>
<td>Medicare</td>
<td>Retiree coverage</td>
</tr>
<tr>
<td>Is disabled and covered by a Large Group Health Plan (LGHP) from work, or from a family member who is working...</td>
<td>The employer has less than 100 employees...</td>
<td>Medicare</td>
<td>GHP</td>
</tr>
<tr>
<td></td>
<td>The employer has 100 or more employees, or at least one employer is a multi-employer group that employs 100 or more individuals...</td>
<td>LGHP</td>
<td>Medicare</td>
</tr>
<tr>
<td>Has End-Stage Renal Disease (ESRD) and GHP coverage...</td>
<td>Is in the first 30 months of eligibility or entitlement to Medicare...</td>
<td>GHP</td>
<td>Medicare</td>
</tr>
<tr>
<td></td>
<td>After 30 months...</td>
<td>Medicare</td>
<td>GHP</td>
</tr>
<tr>
<td>Has ESRD and Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage...</td>
<td>Is in the first 30 months of eligibility or entitlement to Medicare...</td>
<td>COBRA</td>
<td>Medicare</td>
</tr>
<tr>
<td></td>
<td>After 30 months...</td>
<td>Medicare</td>
<td>COBRA</td>
</tr>
<tr>
<td>Is covered under Workers’ Compensation (WC) because of a job-related illness or injury...</td>
<td>The patient is entitled to Medicare...</td>
<td>WC (for health care items or services related to job-related illness or injury)</td>
<td>Medicare</td>
</tr>
<tr>
<td>If the patient...</td>
<td>And this condition exist...</td>
<td>Then this program pays first...</td>
<td>And this program pays second...</td>
</tr>
<tr>
<td>------------------</td>
<td>----------------------------</td>
<td>---------------------------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>Has been in an accident where no-fault or liability insurance is involved...</td>
<td>The patient is entitled to Medicare...</td>
<td>No-fault or liability insurance (for accident related health care services)</td>
<td>Medicare</td>
</tr>
<tr>
<td>Is age 65 or older OR is disabled and covered by Medicare and Consolidated Omnibus Budget Reconciliation Act (COBRA)...</td>
<td>The patient is entitled to Medicare...</td>
<td></td>
<td>Medicare</td>
</tr>
<tr>
<td>Is age 65 or older OR is disabled and covered by Medicare and Consolidated Omnibus Budget Reconciliation Act (COBRA)...</td>
<td>The patient is entitled to Medicare...</td>
<td></td>
<td>Medicare</td>
</tr>
<tr>
<td>Has Veterans Health Administration (VHA) benefits...</td>
<td>Receives VHA authorized health care services at a non-VHA facility...</td>
<td></td>
<td>VHA</td>
</tr>
</tbody>
</table>

### MEDICARE SECONDARY PAYER (MSP) INFORMATION THAT PROVIDERS OR SUPPLIERS MUST OBTAIN FROM A BENEFICIARY OR REPRESENTATIVE

Providers and suppliers are required by law to collect information from beneficiaries regarding the availability of other health insurance related to the items or services included on the claim. In addition, Medicare regulations in 42 CFR 489.20(g) require that providers and suppliers must agree “to bill other primary payers before billing Medicare”. Thus, any provider that bills Medicare for items and services must determine whether or not Medicare is the primary payer. This must be accomplished by asking beneficiaries, or their representatives, questions concerning the beneficiary’s MSP status. If providers fail to provide correct and accurate claims with Medicare, regulations permit Medicare to recover its conditional payments to them.

### COLLECTING BENEFICIARY MEDICARE SECONDARY PAYER (MSP) INFORMATION

Generally, Medicare policy requires providers to update beneficiary MSP information for every admission, outpatient encounter, or start of care prior to submitting a bill to Medicare. However, there are some exceptions. For additional information regarding those exceptions, refer to Chapter 3 of the Medicare Secondary Payer Manual, available at [www.cms.hhs.gov/Manuals/IOM/list.asp](http://www.cms.hhs.gov/Manuals/IOM/list.asp) on the CMS website. Search for publication #100-05.
When COBRA Applies

COBRA is a law that requires employers with 20 or more employees to allow employees and their dependents to keep their group health coverage for a time after they leave their GHP. This is called “continuation coverage” and can last up to 18, 29, or 36 months (in some cases). COBRA and Medicare interact as follows:

- If the beneficiary or spouse are age 65 or over and have COBRA, Medicare is the primary payer.
- If the beneficiary or family member has Medicare based on disability and has COBRA, Medicare is the primary payer.
- If the beneficiary or family member has Medicare based on ESRD, COBRA is the primary payer for a 30-month period and Medicare is secondary.

Workers’ Compensation Medicare Set-Aside Arrangements (WCMSAs) for Worker’s Compensation (WC) Settlements

Medicare may remain secondary payer even after a WC settlement. If a WC settlement includes compensation for future treatment of medical conditions related to the work-related illness or injury and CMS approved the amounts that were set aside to consider Medicare's interests, then those amounts are referred to as a WCMSA. All WCMSA proposals with the exception of Louisiana and New Jersey must be submitted for CMS Regional Office review at:

Centers for Medicare & Medicaid Services
C/O Coordination of Benefits Contractor (COBC)
WCMSA Proposal/final settlement
P.O. Box 660
New York, NY 10274-0660

The two exceptions for review jurisdiction are Louisiana and New Jersey, which are forwarded to the Atlanta Regional Office.

Once the WCMSA proposal has been recorded in a centralized database, the proposal is forwarded to the Regional Office that has jurisdiction for review of the proposal. Access more detailed information about the process or determine which Regional Office has jurisdiction for review at www.cms.hhs.gov/WorkersCompAgencyServices?01_overview.asp on the CMS website. In these situations, providers and suppliers would only bill the set-aside account. Once the set-aside account is depleted, Medicare becomes primary. The beneficiary's set-aside balance can be checked by contacting the Carrier or administrator of the WCMSA.

SPECIFIC BENEFICIARY MEDICARE SECONDARY PAYER (MSP) INFORMATION THAT MUST BE COLLECTED

There are certain questions that providers should ask of Medicare beneficiaries upon each start of care to help identify other payers that may be primary to Medicare. There are questionnaire tools available that a provider can use to gather insurer information depending on the beneficiary type. For example, the Part A Other Insurer Intake Tool is available at www.cms.hhs.gov/ProviderServices/04_PartAOtherInsurerIntakeTool.asp on the CMS website, and the Part B Other Insurer Data Gathering Tool is available at www.cms.hhs.gov/ProviderServices/05_%20PartBOtherInsurerIntakeTool.asp on the CMS website.
ONLINE VERIFICATION OF MEDICARE SECONDARY PAYER (MSP) INFORMATION

Providers with online capability may now access the following MSP information via the Common Working File (CWF) MSP auxiliary file:

- MSP effective date
- MSP termination date
- Patient relationship
- Subscriber name
- Subscriber policy number
- Insurer type
- Insurer information to include name, group number, address, city, state, and ZIP code
- MSP type
- Remarks code
- Employer information to include name, address, city, state, and ZIP code
- Employee data to include ID number

At the provider’s discretion, these data may be viewed during either the admission or the billing process. However, the data must be viewed before the bill is submitted to Medicare.

RETENTION REQUIREMENTS FOR MEDICARE SECONDARY PAYER (MSP) DOCUMENTATION

The provider should retain a copy of the completed admission questionnaires on-file or online for audit purposes. This demonstrates that the provider has investigated with the beneficiary to determine if there is other primary payer coverage. The beneficiary does not need to sign the forms. It is prudent for providers to retain these records for 10 years in a paper, optical image, microfilm or microfiche, or online format.

SUBMITTING A MEDICARE SECONDARY PAYER (MSP) CLAIM

Specific instructions for submitting MSP claims are included in Chapter 3, MSP Provider Billing Requirements, of the Medicare Secondary Payer Manual available at www.cms.hhs.gov/Manuals/IOM/list.asp on the CMS website. Search for publication #100-05.

WHEN MEDICARE PAYS FIRST IN A MEDICARE SECONDARY PAYER (MSP) SITUATION

Medicare will pay first in an MSP situation called “Conditional Primary Medicare Benefits”. There is frequently a long delay between occurrence of an injury and the decision by the state Workers’ Compensation (WC) agency in cases where compensability is being contested or is in a comparative liability action. A denial of Medicare benefits pending outcome of the final decision means that beneficiaries might be required to advance their own funds to pay for expenses that are eventually covered by WC, the liability insurer, the no-fault insurer, or Medicare. To avoid imposing hardship on Medicare beneficiaries pending such decision, conditional Medicare payments may be made. Such payments are conditional upon reimbursement to the Medicare Trust Fund if it is later determined that the services are covered by WC, the no-fault insurer, or the liability insurer. Conditional payments may also be paid for services denied in limited situations.

Conditional primary Medicare benefits may be paid if the beneficiary, provider, physician or supplier has filed a proper claim with the applicable primary insurer (state WC, liability, and/or no-fault plan), and:

- Payments expected from the applicable plans are not paid promptly (i.e., within 120 days of receipt of the claim at a minimum) for any reason except when the plan claims that its benefits are secondary to Medicare.
The properly submitted claim was denied in whole or in part
Because of physical or mental incapacity of the beneficiary, a proper claim was not filed with the primary insurer

When such conditional Medicare payments are made, they are made on the condition that both the insurer and beneficiary will reimburse the program to the extent that payment is subsequently made by the insurer.

WHAT IS A REMITTANCE ADVICE (RA)?

A Remittance Advice (RA) is a notice of payments and adjustments sent to providers, billers, and suppliers. After a claim has been received and processed, a Medicare contractor produces the RA, which may serve as a companion to a claim payment(s) or as an explanation when there is no payment. The RA explains the reimbursement decisions including the reasons for payments and adjustments of processed claims. The RA can take the form of an Electronic Remittance Advice (ERA) or a Standard Paper Remittance Advice (SPR). The codes listed within the RA help the provider identify any additional actions that may be necessary.

REMITTANCE ADVICE (RA) SUBMISSION FORMATS

Although the RA may be submitted in both the ERA or SPR formats, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandates use of the ASC X12 N 835 version 4010A1 format for ERAs. This standard format is also referred to as “the 835”. The 835 has required and situational fields. The required fields are mandatory regardless of provider type. The situational fields are used depending on data content and business context and are used if the situation applies. All of the HIPAA-compliant fields and codes apply universally to all entities that transmit health care information. Medicare also requires that RA codes included within the SPR format be the same as required in the ERA format.

CODES USED WITHIN A REMITTANCE ADVICE (RA)

Fields within the 835 are key elements for providing detailed payment adjustment code information relative to a health care claim(s). If applicable, these codes also describe why the total original charges have not been paid in full. Codes within the 835 represent a standardized reason or condition that relates to the service or claim. Although several codes should appear on an RA, all of the applicable code types may not appear at the same time. The codes may be medical or non-medical, and use of a code may vary according to the provider submitting the claim. Refer to Section 8 of this guide for more information regarding HIPAA-compliant code sets.

Two of the most frequently used code sets include the Claim Adjustment Reason Codes (CARCs) and the Remittance Advice Remark Codes (RARCs). CARCs indicate an adjustment, which means that the codes must communicate why a claim or service line was paid differently than it was billed. If there is no adjustment to a claim/line, then there is no CARC. Under HIPAA, it is important to understand the term “adjusted”. Adjusted indicates that there is a denied...
payment, zero payment, partial payment, reduced payment, penalty applied, additional payment, or supplemental payment.

RARCs are used to convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a CARC. An RARC may be used at either the claim level or service-line level if it is appropriate for the specific situation. Use of an RARC at the claim level conveys information about claim level adjustments or about the overall processing of the claim. Use of RARCs within the service-line conveys information about adjustments for the specific service-line or about the processing of those services. Since RARCs provide information about remittance processing or further explain an adjustment, RARCs are seldom used unless there is an adjustment to report.

Finally, it is important to understand the difference between a CARC and an RARC. CARCs explain an adjustment (an amount paid that is different than the amount billed, including a zero payment or a denial) to the amount submitted by the provider. RARCs accomplish two objectives. RARCs convey informational messages about general remittance practices or they provide a supplemental explanation for an adjustment already described by a CARC.

It is important to review the CARCs and the RARCs along with other information regarding the 835. These codes help the biller understand the specific business reason for any denial or reduction in payment before making an inquiry to Medicare.

Providers who electronically receive an RA must be prepared to receive the notice in HIPAA standard format (ASC X12N Transaction 835 version 4010A1), which was required as of October 16, 2003. As of June 1, 2006, Medicare Contractors no longer mail an SPR to suppliers receiving ERA transactions for 45 days or more.

In addition to the RA, Medicare notifies the beneficiary using a Medicare Summary Notice (MSN). The format of notification that the beneficiary receives may vary depending upon the Medicare Contractor that processes the claim.

**HOW IS A BENEFICIARY NOTIFIED OF DISCONTINUED SERVICES?**

Whenever a provider believes that a service or item may not be covered by Medicare as medically reasonable and necessary for one of several denial reasons, such as statutory exclusions that trigger Financial Liability Protections (FLPs), the provider has historically provided the beneficiary with an Advance Beneficiary Notice (ABN) of Medicare’s likely denial of payment. In all situations where providers discontinue or deny Medicare services, the beneficiary has a right to receive written notification as to the reason the services will no longer be furnished or expected to be paid for by Medicare.

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**RARC and CARC Information**

The most current code lists and a description of RARCs and CARCs can be found at [www.wpc-edi.com/codes](http://www.wpc-edi.com/codes) on the Web. This code list is updated three times per year.
Financial Liability Protections (FLPs)

FLPs apply solely to denials of Medicare payment on the basis of one of the statutory exclusions that, by law, trigger FLPs. The following is a list of exclusions that trigger FLPs and require the provider to send an ABN to the beneficiary:

- **Section 1862(a)(1)** - “medical necessity” exclusion denials per Limitation on Liability (LOL) Section 1879(a)-(g) and per Refund Requirement (RR) Section 1842(l) and Section 1834(j)(4)
- **Section 1862(a)(9)** - “custodial care” exclusion denials - per LOL Section 1879(a)-(g)
- **Section 1814(a)(2)(C) and Section 1835(a)(2)(A)** - homebound and intermittent home health care denials - per LOL Section 1879(g)(1)
- **Section 1861/dd)(3)(A)** - denials because the beneficiary in hospice is found not to be terminally ill - per LOL Section 1879(g)(2)
- **Section 1834(a)(17)FIRST(B)** - prohibited telephone solicitations (“cold calls”) DME denials - per RR.
- **Section 1834(j)(1)** - failure to have a supplier number DMEPOS denial - per RR.
- **Section 1834(a)(15)** - payment denied in advance (advance coverage determination) DME denials - per RR.

If the provider does not provide the patient with an ABN, the patient cannot be held financially liable for the service/item if Medicare denies payment. Beneficiaries must be notified that payment might be denied or reduced before a service is rendered. The beneficiary may then decide whether he or she wants and is willing to pay for the service. If the provider properly notifies the patient in advance that payment for the service may be denied or reduced, the provider is not held financially liable for the services and may seek payment from the patient if Medicare denies payment.

As of July 1, 2005, all Home Health Agencies (HHAs), Skilled Nursing Facilities (SNFs), Comprehensive Outpatient Rehabilitation Facilities (CORFs), and hospice facilities must notify beneficiaries covered under Medicare of their right to an expedited review process when these providers anticipate that their coverage will end. Also as of July 1, 2005, providers must provide notification using one of the following new expedited review notices to notify beneficiaries of discontinuation of coverage:

- **Form CMS-10123**: An Office of Management and Budget (OMB)-approved generic notice
- **Form CMS-10124**: An OMB-approved detailed notice

As of October 1, 2005, affected providers and suppliers must use either the two notices listed above, or one of the following standardized legacy ABN notices that have been in use by CMS:

- **Form CMS-R-131**: Advance Beneficiary Notice - there are two versions of the ABN that a provider should use
- **Form CMS-R-131-G**: Advance Beneficiary Notice (General Use)
- **Form CMS-R-131-L**: Advance Beneficiary Notice (Laboratory Tests)
- **Form CMS-R-296**: Home Health Advance Beneficiary Notice (HHABN)
ADVANCE BENEFICIARY NOTICE (ABN) FOR SERVICES PROVIDED PER REFERRAL OR ORDER OF ANOTHER PHYSICIAN

Providers must be aware of the coverage requirements for the services they provide (if they have been made available) to a patient based on a referral or order of a physician. In most cases, the availability of the coverage requirements indicates that the provider knew, or should have known, that payment for the item/service might be denied or reduced.

For services ordered by another physician (e.g., diagnostic tests), the provider furnishing the service is in the best position to determine the likelihood of denial or reduction of payment and, therefore, should provide a proper ABN to the patient. The physician who ordered the services may provide the ABN, but is not required to do so. The provider who actually furnishes the service is responsible for beneficiary notification and can be held financially liable for the service if payment is denied or reduced. Also, the provider furnishing the services may be required to produce a copy of the ABN. In addition, if the ABN is considered unacceptable, the provider furnishing the services will be financially liable for those services.

ADVANCE BENEFICIARY NOTICE (ABN) MODIFIERS

Modifiers were developed to allow practitioners and suppliers to bill Medicare for items and services that are statutorily not covered or do not meet the definition of a Medicare benefit, and items and services not considered reasonable and necessary by Medicare. The modifiers are used for services billed and for items and supplies billed to the Medicare Contractor. Table 3-3 provides and describes the modifier codes used for Medicare Contractor claims.
Table 3-3. ABN Modifiers for Carrier or DMERC Claims

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Explanation of Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>GA</td>
<td>Indicates that the physician, practitioner, or supplier expects Medicare to deny item or service and they do have an ABN signed by the beneficiary on file.</td>
</tr>
<tr>
<td>GY</td>
<td>Indicates that the physician, practitioner, or supplier deems the item or service to be statutorily excluded or not meeting the definition of any Medicare benefit, therefore it is non-covered or is not a Medicare benefit.</td>
</tr>
<tr>
<td>GZ</td>
<td>Indicates that the physician, practitioner, or supplier expects the item or service to be denied in a case where an ABN would be appropriate and they do not have an ABN signed by the beneficiary on file.</td>
</tr>
</tbody>
</table>

Assigned or non-assigned claims billed to Medicare Part B must contain the “GA” modifier next to each applicable service for which the proper ABN has been given to, and signed by, the patient. The ABN form does not need to be submitted with the claim, but a copy of the signed document must be maintained (e.g., within the patient’s medical records).

When Medicare Contractor claims are being filed, the “GA” and “GZ” modifiers should be used with the appropriate Healthcare Common Procedure Coding System (HCPCS) code whenever one is available. This alphanumeric code is used to describe the Durable Medical Equipment (DME) provided to the beneficiary. In cases where there is no specific HCPCS code available to describe the DME, the “A9270” HCPCS code must be used by suppliers to bill for statutorily not covered items and items that do not meet the definitions of a Medicare benefit.

Providing a Notice of Exclusions from Medicare Benefits (NEMB) - Form CMS-20007

The general use Form CMS-20007 NEMB may be used in any case to advise beneficiaries that Medicare will not pay for particular items or services that are not Medicare benefits before the items are furnished. NEMBs allow beneficiaries to make informed consumer decisions about receiving items or services for which they must pay out-of-pocket and to be more active participants in their own health care treatment decisions. Whenever it is inappropriate to use an ABN, providers may voluntarily use an NEMB to advise their Medicare patients of the services that Medicare never covers.

CMS has also developed draft customized NEMBs for the following provider types:

- **Form CMS-10111**: Notice of Exclusions from Medicare Benefits - Home Health Agency (HHA)
- **Form CMS-20014**: Notice of Exclusions from Medicare Benefits - Skilled Nursing Facility (NEMB-SNF)

Latest HCPCS Codes

The most recently posted HCPCS codes are available at [www.cms.hhs.gov/MedHCPCSGenInfo/](http://www.cms.hhs.gov/MedHCPCSGenInfo/) on the CMS website.
General use and draft NEMB forms and additional information regarding providing written advanced notice to patients that Medicare may not or will not pay for the services suggested by the providers can be found at [www.cms.hhs.gov/BNI](http://www.cms.hhs.gov/BNI) on the CMS website.

**Appropriate Use of the ABN vs. NEMB with Services Subject to the Outpatient Therapy Caps**

Physicians and suppliers are encouraged (but are not required) to use the NEMB form to inform beneficiaries of the outpatient therapy financial limitations (therapy caps) and the cap exception process. Therapy furnished beyond the therapy cap limits are not covered unless the beneficiary qualifies for a cap exception.

The ABN is required to be given to a beneficiary whenever the treating clinician determines that the services being provided are usually covered services, but are no longer expected to be covered because they do not satisfy Medicare’s medical necessity requirements. The ABN applies to services that are provided BEFORE the outpatient therapy cap limit is exceeded. After the cap limit is exceeded, only the NEMB is appropriate, regardless of whether the services qualified for an exception from the outpatient therapy cap limits or not.

Additional details related to outpatient therapy services use of the ABN and NEMB are available in Chapter 5 of the Medicare Claims Processing Manual available at [www.cms.hhs.gov/Manuals/IOM/list.asp](http://www.cms.hhs.gov/Manuals/IOM/list.asp) on the CMS website. Search for publication #100-04.

Providers may use notices of their own design rather than the general use or a draft NEMB form. Some professional associations, with the assistance and approval of CMS, have developed service-specific NEMB-type notices to advise Medicare beneficiaries of the limits of Medicare coverage for certain items and services. These service-specific notices are not government notices; they are considered proprietary notices of the authoring associations.

**WHAT SPECIAL CONSIDERATIONS ARE THERE FOR SUBMITTING DURABLE MEDICAL EQUIPMENT (DME) SUPPLIER CLAIMS TO A MEDICARE CONTRACTOR?**

DME is covered under Medicare Part B insurance and defined as equipment that can withstand repeated use, is primarily used for a medical purpose, and is generally not used in the absence of illness or injury. Suppliers submit DME claims to a regional Medicare Contractor who will process a DME claim based on a written order submitted by a supplier. Prior to submitting a claim to the Medicare Contractor, the supplier must have the written order and a Certificate of Medical Necessity CMN (if applicable), information from the treating physician concerning the patient’s diagnosis (if an ICD-9-CM code is required on the claim), and any information required for the use of specific modifiers or attestation statements as defined in certain Medicare Contractor policies.
**SUBMITTING WRITTEN ORDERS WITH DURABLE MEDICAL EQUIPMENT (DME) CLAIMS**

Written orders are acceptable for all transactions involving DME. Written orders can be submitted as a photocopy, facsimile image, electronic file, or an original “pen-and-ink” document. The supplier must obtain a written order that meets the requirements of this section. If the written order is for supplies that will be provided on a periodic basis, the written order should include:

- The start date of the order
- A detailed description containing all options or additional features that will be separately billed or that will require an upgrade code; the description can be either a narrative description (e.g., lightweight wheelchair base) or a brand name/model number

**Note:** Someone other than the physician may complete the detailed description of the item or service. However, the treating physician must review the detailed description and personally sign and date the order to indicate agreement.

- Appropriate information on the quantity used
- Frequency of change
- Indication of whether the order is a rented item, specifying the duration of need (if necessary)
- The name of the drug, concentration level (if applicable), dosage, frequency of administration, and duration of infusion (if applicable) if the supply is a drug

Medical necessity information (e.g., an ICD-9-CM diagnosis code, narrative description of the patient’s condition, abilities, limitations, etc.) is NOT considered to be part of the order, although it may be included within the same document as the order.

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A nurse practitioner or Clinical Nurse Specialist (CNS) may provide a verbal order, then sign and date the subsequent written order when he or she is:

- Treating the beneficiary for the condition for which the item is needed
- Practicing independently of a physician
- Billing Medicare for other covered services using their own provider number
- Permitted to do all of the above in the state in which services are provided

A Physician’s Assistant (PA) may provide a verbal order, then sign and date the subsequent written order, when he or she:

- Meets the Medicare definition of a PA (individual with two or more years of advanced training who is exam-certified, works with a doctor, and can perform some of the services that a doctor can provide)
- Treats the beneficiary for the condition for which the item is needed
- Practices under the supervision of a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.)
- Has their own Unique Physician Identification Number (UPIN)/National Provider Identifier (NPI)
- Is permitted to do all of the above in the state in which services are provided

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**Sample Written Order**

An order for surgical dressings might specify one 4 x 4 hydrocolloid dressing that is changed 1-2 times per week for one month, or until the ulcer heals.
SUBMITTING WRITTEN DME ORDERS PRIOR TO DELIVERY

A written order prior to delivery is required for certain DME items. For these items, the supplier must have received a written order that has been both signed and dated by the treating physician and that meets the requirements specified in Section 3, Submitting Written Orders with Durable Medical Equipment (DME) Claims, of this guide. If a supplier bills for an item without a written order when the supplier is required to have a written order prior to delivery, the item will be denied for not meeting the benefit category and therefore cannot be appealed by the supplier.

Recent legislative changes mandated by Sections 5101(a) and 5101(b) of the Deficit Reduction Act of 2005 (DRA) mandate changes in the way Medicare makes payment for certain DME items. Section 5101(a) revises the payment rules for capped rental DME. After 13 months, the beneficiary owns the capped rental DME item, and after that time, Medicare pays for reasonable and necessary maintenance and servicing of the item. The provision applies to beneficiaries renting an item for which the first rental month occurs on or after January 1, 2006. Section 5101(b) limits the total number of continuous rental months for which Medicare will pay for oxygen equipment up to 36 months. After the 36th month, the beneficiary will own the oxygen equipment.