Medicare Claims Processing Manual
Chapter 2 - Admission and Registration Requirements

Table of Contents
(Rev. 12423; Issued: 12-20-23)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

01 - Purpose of Chapter
(Rev. 3441, Issued: 01-15-16, Effective; 12-31-13; ASC X12: 01-01-12, MAC Implementation: 02-16-16; ASC X12: 02-16-16)

This chapter describes general requirements with respect to verifying an individual's Medicare eligibility and entitlement status for providers, suppliers, A/B MACs (A), (B), and (HHH), and DME MACs. It also includes general requirements for hospitals for determining the source admission for use later in the claims process.

05 - Definition of Provider and Supplier
(Rev. 12423; Issued: 12-20-23; Effective: 01-01-24; Implementation: 01-02-24)

This chapter uses the definition of provider and supplier found in 42 CFR 400.202. These are:

> **Provider** means a hospital, a CAH, a skilled nursing facility, a comprehensive outpatient rehabilitation facility, a home health agency, or a hospice that has in effect an agreement to participate in Medicare, or a clinic, a rehabilitation agency, or a public health agency that has in effect a similar agreement but only to furnish outpatient physical therapy or speech-language pathology services, or a community mental health center that has in effect a similar agreement but only to furnish partial hospitalization *or intensive outpatient* services.

> **Supplier** means a physician or other practitioner, or an entity other than a provider that furnishes health care services under Medicare.

Note that while rural health clinics, Federally qualified health centers, and renal dialysis facilities are suppliers under the regulation, they submit most claims to A/B MACs (A).

10 - General Admission and Registration Rules
(Rev. 3441, Issued: 01-15-16, Effective; 12-31-13; ASC X12: 01-01-12, MAC Implementation: 02-16-16; ASC X12: 02-16-16)

The following is a general description of requirements and prohibited activities that apply to admission for inpatient services or registration for other healthcare services.

Upon admission, Prospective Payment System (PPS) hospitals and acute care hospitals in areas with waivers from PPS are required to give the notice, "An Important Message from Medicare," to beneficiaries (available at www.cms.gov/Medicare/Medicare-General-Information/BNI/downloads/RevisedImportantMessageFromMedicare05_2007.pdf). The facility inserts its Quality Improvement Organization's (QIO) name, address, and phone number. It provides this notice to each Medicare patient or the patient's representative. The CMS does not supply copies of the notice.

Upon admission of a Medicare beneficiary to an institution that bills Medicare, or as soon thereafter as practical, the provider must verify a patient's eligibility in order to process the bill. The provider may obtain this eligibility information directly from the patient or through the provider's A/B MAC (A)'s limited Medicare eligibility data. See §30.6. The provider contacts its A/B MAC (A) to obtain technical instructions regarding how this access may be implemented along with hardware/software compatibility details.

This information does not represent a definitive eligibility status. If the individual is not on file, the provider uses the usual admission and billing procedure in effect, independent of this data access.

Disclosure of CMS eligibility data is restricted under the provisions of the Privacy Act of 1974. This information is confidential, and may be used only for verifying a patient's eligibility to benefits under the Medicare program. Penalties for misuse by anyone may result in being found guilty of a misdemeanor and paying a fine not more than $5,000.

10.1 - Medicare beneficiary identifiers
(Rev. 4247, Issued: 03-01-19, Effective: 04-01-19, Implementation: 04-01 -19)

 The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

The CMS maintains the electronic records for individuals enrolled in the health insurance program. The CMS issues health insurance cards where entitlement is established through the Social Security Administration (SSA), and the Railroad Retirement Board (RRB) issues health insurance cards where entitlement is established through RRB.

See Chapter 2 of the Medicare General Information, Eligibility, and Entitlement Manual (Pub. 100-01) for an extended discussion of HI cards and Medicare beneficiary identifiers.

10.1.1 - Changes to Medicare beneficiary identifier
(Rev. 4247, Issued: 03-01-19, Effective: 04-01-19, Implementation: 04-01 -19)

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Changes in an individual's entitlement to Medicare benefits may result in an individual being assigned a completely different HICN. For example, an individual not entitled to monthly benefits (000-00-0000T) marries and becomes entitled to wife's benefits on her husband's account (111-11-1111B). If a claim is submitted under the old HICN, the Common Working File (CWF) disposition code 51 will notify the A/B MAC (A), (B), (HHH), or DME MAC (whom we will refer to as the MAC when all are meant) of the new HICN. The MAC will annotate its records and use the new HICN when submitting future bills or claims.

10.1.2 - Contractor Procedures for Obtaining Missing or Incorrect Medicare beneficiary identifiers
(Rev. 4247, Issued: 03-01-19, Effective: 04-01-19, Implementation: 04-01 -19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

Upon receipt of a claim or other paper on which the Medicare beneficiary identifier is omitted, incomplete, inconsistent, or obviously incorrect, the MAC submits the claim to CWF with the best information it has available. Depending on the CWF reply, the MAC follows the instructions in Chapter 27 for handling various disposition codes, trailers, and error codes.

10.1.3 - Importance of Medicare beneficiary identifiers
(Rev. 4247, Issued: 03-01-19, Effective: 04-01-19, Implementation: 04-01 -19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

The Medicare beneficiary identifier is used in Medicare records to identify the beneficiary. The provider or supplier obtains this number before billing. See §30 below for a description of appropriate processes for obtaining the Medicare beneficiary identifier.

10.2 - Prohibition Against Waiver of Health Insurance Benefits as a Condition of Admission
(Rev. 3441, Issued: 01-15-16, Effective; 12-31-13; ASC X12: 01-01-12, MAC Implementation: 02-16-16; ASC X12: 02-16-16)

Providers may not require, as a condition of admission or treatment, that a patient agree to waive the right to have services paid for under Medicare. Requiring such a "waiver" is inconsistent with the agreement with CMS, and the "waiver" is not binding upon the patient. Providers have agreed not to charge an individual (except for specified deductible and coinsurance amounts) for services for which such individual is entitled to have payment made or for which he/she would be entitled if the provider complied with the procedural and other requirements of the program. Further, under this provision, the provider must refund any amounts incorrectly collected.

Where a patient who has signed such a waiver, nevertheless, requests payment under the program, the provider must bill the A/B MAC (A) and refund any payments made by the patient, or on the patient's behalf, in excess of permissible charges.

10.3 - Requiring Prepayment as a Condition of Admission is Prohibited
(Rev. 1, 10-01-03)
HO-303, SNF-317

Providers must not require advance payment of the inpatient deductible or coinsurance as a condition of admission. Additionally, providers may not require that the beneficiary prepay any Part B charges as a condition of admission, except where prepayment from non-Medicare patients is required. In such cases, only the deductible and coinsurance may be collected. Where the patient does not have Part B entitlement, the provider will follow the rules in §10.6.

10.4 - When Prepayment May Be Requested
(Rev. 1, 10-01-03)
HO-303.2

The provider may collect deductible or coinsurance amounts only where it appears that the patient will owe deductible or coinsurance amounts and where it is routine and customary policy to request similar prepayment from non-Medicare patients with similar benefits that leave patients responsible for a part of the cost of their hospital services. In admitting or registering patients, the provider must ascertain whether beneficiaries have medical insurance coverage. Where beneficiaries have medical insurance coverage, the provider asks the beneficiary if he/she has a Medicare Summary Notice (MSN) showing his/her deductible status. If a beneficiary shows that the Part B deductible is met, the provider will not request or require prepayment of the deductible.

Except in rare cases where prepayment may be required, any request for payment must be made as a request and without undue pressure. The beneficiary (and the beneficiary's family) must not be given cause to fear that admission or treatment will be denied for failure to make the advance payment.

Providers must insure that the admitting office personnel are informed and kept fully aware of the policy on prepayment. For this purpose, and for the benefit of the provider

and the public, it is desirable that a notice be posted prominently in the admitting office or lobby to the effect that no patient will be refused admission for inability to make an advance payment or deposit if Medicare is expected to pay the hospital costs.

10.5 - Hospital and Skilled Nursing Facility (SNF) Verification of Prior Hospital Stay Information for Determining Deductible and Benefit Period Status
(Rev. 3441, Issued: 01-15-16, Effective; 12-31-13; ASC X12: 01-01-12, MAC Implementation: 02-16-16; ASC X12: 02-16-16)

If it has been determined that Medicare is the primary payer, the hospital or SNF must determine if the patient has been an inpatient in any hospital or SNF, including swing bed stays, during the prior 60 days. If so, the hospital or SNF must determine the admission and discharge dates and the number of days of hospitalization or skilled nursing (as applicable) the patient used in the current benefit period. The admission and discharge dates must be reported on the claim, and the number of days of hospitalization or skilled nursing (as applicable) must be used to calculate the hospital insurance copayment and the number of days remaining in the benefit period.

If the patient indicates he/she was not an inpatient within the last 60 days, the hospital applies the inpatient deductible to the current stay if it is a covered hospital admission. The A/B MAC (A) determines the accuracy of the claim data after receipt of the claim. The remittance advice received from the A/B MAC (A) reflects the amount of deductible (hospital claims) and coinsurance (hospital and SNF claims) applied. If this amount is different from what was billed, the hospital/SNF must correct the records accordingly.

10.6 - Hospitals May Require Prepayment for Noncovered Services
(Rev. 1, 10-01-03)
HO-303.3

With regard to noncovered services (e.g., personal comfort items, a private duty nurse), the hospital may deny such services for which the beneficiary has not paid or offered satisfactory assurance of payment if that is the hospital's practice with nonbeneficiary patients. For example, a private room or TV set need not be furnished to a patient who requests it but is unable to prepay or offer the assurance of payment which is usually required.

Where the individual has exhausted his/her covered inpatient hospital benefits, or cannot supply satisfactory evidence of entitlement under Part A, providers are free to apply to such persons the hospital's usual policy with respect to requiring prepayment or other assurance of payment where the patient has no insurance. In addition, for the beneficiaries receiving covered inpatient services who are not enrolled for medical insurance (Part B), the hospital can apply its usual policy on prepayment or assurance of payment with regard to services of salaried physicians provided.

10.7 - Compliance With Agreement

Providers must conform to the policy set forth in this instruction. Noncompliance will be considered in determining whether the provider is honoring its agreement, under which it may not charge for services for which payment may be made under the Medicare program.

10.8 - Request for Payment Should Be Obtained in All Cases as Protective Application for Hospital Insurance Benefits
(Rev. 1, 10-01-03)
HO-266, HO-307, SNF-407

To become entitled to HI benefits, an individual must not only be eligible, but must also, prior to death, have filed an application for such benefits (or for monthly social security benefits). Even though the individual meets all eligibility requirements, if the individual does not file the necessary application before death, the individual cannot become entitled, and no payment can be made for hospital services. The provider should obtain a written request for title XVIII payment, filed by or on behalf of a patient, upon admission as described in Chapter 1.

Occasionally, a Medicare eligible patient age 65 or over who is admitted to a hospital, has never applied for benefits. A request for payment will protect the eligible patient, the patient's estate, and the provider against the possibility that timely application will not be filed. If the patient refuses to sign the request, the provider will respect the patient's wishes. The provider may then require the patient to pay or give assurance of payment in accordance with customary practice for non-beneficiaries. If the patient cannot sign, and is not accompanied by anyone who can sign on the patient's behalf, an authorized provider official may execute the request for payment on the patient's behalf. The admission record containing the request should contain the patient's name and be signed and dated as of the signature date.

Where the Social Security Office (SSO), upon the provider's inquiry for a claim number, finds that an apparently eligible inpatient has not applied for benefits; and that the filing date established by the written request might permit payment (not otherwise possible) for the individual's inpatient services; the SSO will ask the provider for a photocopy of the admission record containing the signed request. The SSO may ask the provider to file a prescribed application for benefits on behalf of the patient who is incompetent if there is no other qualified applicant.

In the case of a deceased patient, who prior to death signed a document that protected the filing date, a provider may apply on behalf of the patient if no other qualified applicant applies within six months of the date of notice of the need for application. However, where a qualified survivor or representative of the estate refuses to file and states in writing that his/her refusal is based upon the fact that filing would be detrimental to the

deceased's estate, hospital insurance entitlement cannot be established and payment cannot be made for services.

10.9 - A/B MAC (A), (B), or (HHH), or DME MAC Requests to Verify Patient's Medicare beneficiary identifier
(Rev. 4247, Issued: 03-01-19, Effective: 04-01-19, Implementation: 04-01 -19)

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Where the name and Medicare beneficiary identifier information on a claim does not match the CMS central record, the A/B MAC (A), (B), or (HHH), or DME MAC will return the claim to the provider and request the provider to verify the information.

The provider will compare the name and number on the claim with that on provider records. If the information submitted was incorrect, the provider will return the claim to the MAC with the corrected information.

If, however, the information in the provider's records identifying the patient is the same as the information submitted on the claim, the provider will contact the SSO for assistance.

10.10 - A/B MAC (A), (B), or (HHH) or DME MAC Learns Beneficiary is an HMO Enrollee
(Rev. 3441, Issued: 01-15-16, Effective; 12-31-13; ASC X12: 01-01-12, MAC Implementation: 02-16-16; ASC X12: 02-16-16)

If the A/B MAC (A), (B), or (HHH), or DME MAC determines from its records or its query to CMS that a patient is an HMO enrollee, the MAC will return the claim to the provider with instructions to request payment from the HMO for payment, if appropriate.

10.11 - Retroactive Entitlement
(Rev. 3441, Issued: 01-15-16, Effective; 12-31-13; ASC X12: 01-01-12, MAC Implementation: 02-16-16; ASC X12: 02-16-16)

When an application for social security benefits is filed by a person 65 years of age or older, the person may inform the SSO that he/she received hospital services in the retroactive period of up to six months for which he/she may be entitled to benefits. In these cases, the provider may bill for covered retroactive services but must verify the patient's eligibility through the A/B MAC (A), (B), or (HHH), or DME MAC before

billing. If the patient paid, the provider must refund the appropriate amount to the patient.

10.12 - SNF Verification of Prior Hospital Stay and Transfer Requirements
(Rev. 1, 10-01-03)
SNF-414

SNFs must verify that the beneficiary was discharged from a hospital with a transfer agreement with the SNF and that:

  a. The date of discharge is on or after the first day of the month in which the beneficiary became entitled to Medicare;

  b. The hospital stay was at least three calendar days in duration (hospital days to which waiver of liability was applied cannot be used to satisfy the 3-day requirement); and

  c. The 3-day qualifying stay was within 30 days of the SNF admission, unless the rules for exception apply.

The hospital usually sends the SNF a patient transfer form or other record in accordance with the transfer agreement. The dates of the hospital stay are required on the claim.

For more information on the above criteria, see Chapter 8 of the Medicare Benefit Policy Manual.

20 - Obtaining Information to Determine Whether to Bill Medicare or Another Payer
(Rev. 1, 10-01-03)
HO-300, SNF-401

The provider must ascertain whether the patient is a member of a Medicare + Choice organization (M+CO). If the patient is a member of an M+CO, the provider must contact the M+CO specified by the patient or identified on the patient's membership card, so the provider may determine whether to submit the claim to the M+CO.

If the patient indicates that he/she is not a member of an M+CO, the provider, in order to determine whom to bill, develops for situations where Medicare is the secondary payer by obtaining answers to the "Admission Questions to Ask Medicare Beneficiaries" contained in Chapter 3 of the Medicare Secondary Payer Manual. If another insurer is identified as primary to Medicare, the provider follows the procedures in the Medicare Secondary Payer (MSP) Manual.

20.1 - Provider Development of Medicare Secondary Payer
(Rev. 1, 10-01-03)

Medicare is the secondary payer under certain circumstances. See Medicare Secondary Payer (MSP) Manual, Chapter 1, for related instructions.

30 - Provider/Supplier Obtaining/Verifying the Medicare beneficiary identifier and Entitlement Status
(Rev. 4247, Issued: 03-01-19, Effective: 04-01-19, Implementation: 04-01 -19)

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It is important that the patient's Medicare beneficiary identifier be obtained and accurately recorded because the claim cannot be processed if the Medicare beneficiary identifier is missing or incorrect. A social security number is not sufficient.

When a patient 65 years of age or over, or a younger patient who possibly has entitlement to Medicare as a disability beneficiary or under the provisions for coverage of persons needing a kidney transplantation or dialysis, is admitted or registered for services, the provider asks for the health insurance card, Temporary Notice of Medicare Eligibility, or other notice the patient has received from CMS or an A/B MAC (A), (B), (HHH), or DME MAC which shows the Medicare beneficiary identifier. If a patient or prospective patient is within three months of age 65, or is disabled or has ESRD, and has not applied for HI entitlement, the provider advises the patient to contact the SSO, or to have someone do so on the patient's behalf. The provider may arrange with the SSO to routinely bring such cases to the SSO's attention.

This requirement also applies to inpatient services for which no payment is due because providers are required to submit inpatient claims even when benefits are exhausted or are not payable for some reason. The CMS requires this data to record necessary benefit information on CMS records. Where the patient refuses to request payment and refuses to furnish information about his/her Medicare beneficiary identifier, the provider documents the records accordingly and attempts to get the Medicare beneficiary identifier from the SSO.

30.1 - Cross-Reference of Medicare Beneficiary Identifier
(Rev. 4247, Issued: 03-01-19, Effective: 04-01-19, Implementation: 04-01 -19)

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the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

If a beneficiary's entitlement to Medicare has been transferred from one Medicare beneficiary identifier to another, the CWF will cross-reference the old number to the new number. If there has been utilization of benefits under each number, all data will be combined under the new number.

A. Disposition Code 51

1. If, after submitting the admission notice or Part B claim to CMS, the MAC receives a disposition code of 51 with trailer code 01 containing a possible Medicare beneficiary identifier, the MAC investigates the new Medicare beneficiary identifier, and if it believes the new Medicare beneficiary identifier is correct, the MAC resubmits the claim under the new Medicare beneficiary identifier. CWF responds with an appropriate disposition code and any associated trailers for processing the claim.

2. If the MAC receives a disposition code of 51 without trailer code 01, or after investigation determines the Medicare beneficiary identifier in the 01 trailer is incorrect, it denies the claim using the following message:

> Payment cannot be made for the services you received from (name of provider) because we have no record of your Medicare beneficiary identifier. Please write your correct number on the claim and resubmit the claim to (name of provider). If you think the number is right, check with your local Social Security Office.

B. Disposition Code 55

If CWF returns disposition code 55 and trailer code 08 containing an error code of 5052, indicating a mismatch in the beneficiary's personal characteristics, CWF will also return to the MAC what it believes to be the proper information on trailer code 10. The header portion of the response also contains the corrected sex and birth date, if applicable, of the beneficiary.

The MAC investigates the information provided, corrects the information on the claim, and resubmits it to CWF. If the MAC continues to receive a code 55, it contacts the Host through locally established procedures. See Chapter 27.

30.2 - Health Insurance (HI) Card
(Rev. 4247, Issued: 03-01-19, Effective: 04-01-19, Implementation: 04-01 -19)

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beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

As part of health insurance electronic data processing, HI cards are issued by CMS (or by the RRB where railroad retirement beneficiaries are involved) to individuals who have established entitlement to health insurance. (See Chapter 2 of the Medicare General Information, Eligibility, and Entitlement Manual.) The health insurance card is used to identify the individual as being entitled and serves as a source of information required to process Medicare claims or bills. The health insurance card displays the beneficiary's name, sex, Medicare beneficiary identifier, and effective date of entitlement to hospital insurance and/or medical insurance.

If any MAC receives an inquiry about replacing a lost or destroyed HI card, it informs the inquirer to get in touch with the SSO nearest the inquirer's address for assistance. SSO addresses are generally listed in local telephone directories under "Social Security Administration."

A health insurance card is acceptable without a signature, but the provider will ask the patient to sign it.

30.3 - Temporary Eligibility Notice
(Rev. 4247, Issued: 03-01-19, Effective: 04-01-19, Implementation: 04-01 -19)

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The SSO may issue a temporary health insurance eligibility notice, pending the issuance of a health insurance card, when the beneficiary is in need of immediate medical services. The provider may obtain the patient's name and Medicare beneficiary identifier from the temporary eligibility notice. See Chapter 2 of the Medicare General Information, Eligibility, and Entitlement Manual for an example of the temporary notice.

For claims processed by the A/B MAC (B) or DME MAC, the individual, the individual's physician, or other supplier must show the Medicare beneficiary identifier on the request for Medicare payment and on other related bills and documents. Because Health Insurance records are maintained by the individual's Medicare beneficiary identifier, the Medicare beneficiary identifier must be used on all communications. claim number, the claim number must be used on all communications.

30.4 - Certificate of Social Insurance Award
(Rev. 4247, Issued: 03-01-19, Effective: 04-01-19, Implementation: 04-01 -19)

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Health insurance beneficiaries receive a Certificate of Social Insurance Award, SSA-30, showing the Medicare beneficiary identifier, dates of entitlement to Part A and/or Part B benefits, and the following statement:

> This notice may be used if Medicare services are needed before you receive your health insurance card.

30.5 - Medicare Summary Notice (MSN)
(Rev. 4247, Issued: 03-01-19, Effective: 04-01-19, Implementation: 04-01 -19)

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If patients cannot furnish their health insurance cards when admitted, they may have a MSN form showing the Medicare beneficiary identifier. A notice is mailed to a beneficiary shortly after Part A or Part B benefits have been paid on the beneficiary's behalf. Deductible status is also shown on these forms.

30.6 - Provider Access to CMS and A/B MAC (A) or (HHH) Eligibility Data
(Rev. 4247, Issued: 03-01-19, Effective: 04-01-19, Implementation: 04-01 -19)

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The A/B MAC (A) or (HHH) will allow only Medicare certified providers as defined in §§1861 and 1866(e) of the Social Security Act (the Act) and their billing agents automated access to beneficiary eligibility data. Disclosure of CWF eligibility data is

restricted under provisions of the <u>Privacy Act of 1974, 5 U.S.C §552a</u>. Under limited circumstances, the Privacy Act permits CMS to disclose information without consent of the individual. One circumstance is for "routine uses," that is, disclosure for purposes that are compatible with the purpose for which CMS collects the information. In the case of this provider access, a routine use exists which permits release of data to providers or their authorized billing agents for the purpose of verifying a patient's eligibility for benefits under the Medicare program. The use of the data by a provider in preparing claims for hospital-based physicians would be an example of unauthorized use because the physicians are not Medicare providers as defined in the Act.

A/B MACs (A) or (HHH) will adjust their systems to accept the revised standard HIQA/HUQA records from the CMS CWF. The standard data elements to be made available to providers are listed below:

- Medicare beneficiary identifier;

- Beneficiary:

  o Last name (first six positions)/first initial;

  o Date of birth;

  o Sex;

  o Date of death;

  o Lifetime reserve days remaining;

  o Lifetime psychiatric days remaining (requesting hospital must use a psychiatric provider number to obtain this data);

  o Cross reference Medicare beneficiary identifier;

  o Current and prior A and B entitlements, with start and stop dates for Part A, Part B, ESRD, HMO, and hospice; and

  o Spell of illness (applicable spell based on the date entered by the provider and the next most recent spell):

    - Hospital full days remaining;

    - Hospital coinsurance days remaining;

    - SNF full days remaining;

    - SNF coinsurance days remaining;

- Part A cash deductible remaining to be met;

- Date of earliest billing action for indicated spell-of-illness;

- Date of latest billing action for indicated spell-of-illness;

- Blood deductible (combined annual Part A and B remaining to be met for applicable year entered by provider);

- Part B trailer year (applicable year based on date entered by provider);

- Part B cash deductible;

- Physical therapy/speech-language pathology limit (physical therapy and speech-language pathology are applicable to physical therapy limit);

- Occupational therapy limit;

- Hospice data (applicable periods based on the date entered by the provider and the next most recent period);

- ESRD indicator (shows beneficiary is currently entitled);

- REP payee indicator;

- MSP indicator;

- Home Health Benefit Period:

  o Part A visits remaining;

  o Part B visits applied;

  o Date of earliest billing action for home health benefit period;

  o Date of latest billing action for home health benefit period.

- HMO information (applicable periods based on date entered by the provider):

  o Name;

  o Identification number;

o   ZIP Code;

o   Option code;

o   Start date;

o   Termination date;

o   Pap smear screening risk indicator, professional date, and technical date;

o   Mammography screening risk indicator (applicable to screening services prior to January 1, 1998), professional date, and technical date;

o   Colorectal screening (no risk indicator); procedure code, professional date, and technical date;

o   Pelvic screening risk indicator and professional date;

o   Pneumococcal pneumonia vaccine (PPV) date;

o   Influenza virus vaccine date; and

o   Hepatitis B vaccine date.

See Chapter 10 of this manual for a complete discussion of the HIQH (Health Insurance Query for Home Health Agencies).

The A/B MAC (A) will make sure that psychiatric information is not being made available to all hospitals. This information is to be made available **only** to psychiatric hospitals or hospitals that furnish inpatient psychiatric hospital services.

Providers may use direct entry terminals or dial-up terminals to inquire about beneficiary eligibility utilization and deductible status. The A/B MAC (A) must use either the HIQA screen display (see §30.6.1.1) or create its own Customer Information Control System (CICS) screens from the HUQA data records (see §§30.6.1.2 and 30.6.1.3). Providers may not have access to any other CWF records, e.g., the health insurance master record (HIMR). The data must be from CWF. The A/B MAC (A) will not substitute local history.

30.6.1 - Reserved
(Rev. 3441, Issued: 01-15-16, Effective; 12-31-13; ASC X12: 01-01-12, MAC Implementation: 02-16-16; ASC X12: 02-16-16)

30.6.1.1 - Part A Inquiry (HIQA) Screen Display
(Rev. 3441, Issued: 01-15-16, Effective; 12-31-13; ASC X12: 01-01-12, MAC Implementation: 02-16-16; ASC X12: 02-16-16)

All the data elements are explained in full for proper use. A/B MACs (A) or (HHH) should access this screen to transmit data to their providers and suppliers when supplying data for §30.6.1.2.

30.6.1.2 - Part A Inquiry Reply (HIQAR) Screen Display
(Rev. 1, 10-01-03)
A3-3508.4

This screen format can be used to pass beneficiary entitlement and utilization data to the provider. It is described in the CWF Documentation, Chapter VII, Section H, pages 1 through 24. Refer to the CWF Documentation when providing utilization data to the provider.

30.6.1.3 - Part A Inquiry (HUQA) Data
(Rev. 1, 10-01-03)
A3-3508.5

This transaction may be used to obtain the HUQA dataset. (See §30.6.) Also, refer to Chapter II of the CSC maintained CWF Documentation.

30.6.1.4 - Part A Inquiry Reply (HUQAR) Data
(Rev. 3441, Issued: 01-15-16, Effective; 12-31-13; ASC X12: 01-01-12, MAC Implementation: 02-16-16; ASC X12: 02-16-16)

This response can be used to create the A/B MAC (A)'s or (HHH)'s own screens to return beneficiary eligibility and utilization data to providers.

30.6.1.5 - Health Insurance Query for Home Health Agencies (HIQH)
(Rev. 3441, Issued: 01-15-16, Effective; 12-31-13; ASC X12: 01-01-12, MAC Implementation: 02-16-16; ASC X12: 02-16-16)

This transaction, which is available through A/B MAC (HHH) remote access, is used by HHAs to ascertain whether an episode has been opened for a given beneficiary by another provider (who is the primary HHA) and to track episodes for beneficiaries for whom the inquiring HHA is the primary HHA.

30.6.2 - Reserved

(Rev. 3441, Issued: 01-15-16, Effective; 12-31-13; ASC X12: 01-01-12, MAC Implementation: 02-16-16; ASC X12: 02-16-16)

30.6.3 - Reserved

(Rev. 3441, Issued: 01-15-16, Effective; 12-31-13; ASC X12: 01-01-12, MAC Implementation: 02-16-16; ASC X12: 02-16-16)

30.6.4 - Reserved

(Rev. 3441, Issued: 01-15-16, Effective; 12-31-13; ASC X12: 01-01-12, MAC Implementation: 02-16-16; ASC X12: 02-16-16)

30.6.5 - Reserved

(Rev. 3441, Issued: 01-15-16, Effective; 12-31-13; ASC X12: 01-01-12, MAC Implementation: 02-16-16; ASC X12: 02-16-16)

30.6.6 - Reserved

(Rev. 3441, Issued: 01-15-16, Effective; 12-31-13; ASC X12: 01-01-12, MAC Implementation: 02-16-16; ASC X12: 02-16-16)

30.8 - Reserved
(Rev. 3441, Issued: 01-15-16, Effective; 12-31-13; ASC X12: 01-01-12, MAC Implementation: 02-16-16; ASC X12: 02-16-16)

30.10 - Reserved
(Rev. 3441, Issued: 01-15-16, Effective; 12-31-13; ASC X12: 01-01-12, MAC Implementation: 02-16-16; ASC X12: 02-16-16)

30.11 - Reserved
(Rev. 3441, Issued: 01-15-16, Effective; 12-31-13; ASC X12: 01-01-12, MAC Implementation: 02-16-16; ASC X12: 02-16-16)

30.12 - Reserved
(Rev. 3441, Issued: 01-15-16, Effective; 12-31-13; ASC X12: 01-01-12, MAC Implementation: 02-16-16; ASC X12: 02-16-16)

30.13 - Reserved
(Rev. 3441, Issued: 01-15-16, Effective; 12-31-13; ASC X12: 01-01-12, MAC Implementation: 02-16-16; ASC X12: 02-16-16)

30.14 - Reserved
(Rev. 3441, Issued: 01-15-16, Effective; 12-31-13; ASC X12: 01-01-12, MAC Implementation: 02-16-16; ASC X12: 02-16-16)

30.15 - Reserved

(Rev. 3441, Issued: 01-15-16, Effective; 12-31-13; ASC X12: 01-01-12, MAC Implementation: 02-16-16; ASC X12: 02-16-16)

30.16 - Reserved
(Rev. 3441, Issued: 01-15-16, Effective; 12-31-13; ASC X12: 01-01-12, MAC Implementation: 02-16-16; ASC X12: 02-16-16)

30.17 - Reserved
(Rev. 3441, Issued: 01-15-16, Effective; 12-31-13; ASC X12: 01-01-12, MAC Implementation: 02-16-16; ASC X12: 02-16-16)

30.18 - Reserved
(Rev. 3441, Issued: 01-15-16, Effective; 12-31-13; ASC X12: 01-01-12, MAC Implementation: 02-16-16; ASC X12: 02-16-16)

30.19 - Reserved
(Rev. 3441, Issued: 01-15-16, Effective; 12-31-13; ASC X12: 01-01-12, MAC Implementation: 02-16-16; ASC X12: 02-16-16)

30.19.1 - Reserved
(Rev. 3441, Issued: 01-15-16, Effective; 12-31-13; ASC X12: 01-01-12, MAC Implementation: 02-16-16; ASC X12: 02-16-16)

30.19.2 - Reserved
(Rev. 3441, Issued: 01-15-16, Effective; 12-31-13; ASC X12: 01-01-12, MAC Implementation: 02-16-16; ASC X12: 02-16-16)

30.19.3 - Reserved
(Rev. 3441, Issued: 01-15-16, Effective; 12-31-13; ASC X12: 01-01-12, MAC Implementation: 02-16-16; ASC X12: 02-16-16)

30.19.4 - Reserved
(Rev. 3441, Issued: 01-15-16, Effective; 12-31-13; ASC X12: 01-01-12, MAC Implementation: 02-16-16; ASC X12: 02-16-16)

30.20 - Reserved
(Rev. 3441, Issued: 01-15-16, Effective; 12-31-13; ASC X12: 01-01-12, MAC Implementation: 02-16-16; ASC X12: 02-16-16)

30.21 - Requesting Assistance in Resolving Problem Areas in the Inquiry/Inquiry Response Procedures
(Rev. 1, 10-01-03)
A3-3523, 3-6008

See **§70**.

30.21.1 - HMO-Related Master File Corrections
(Rev. 3441, Issued: 01-15-16, Effective; 12-31-13; ASC X12: 01-01-12, MAC Implementation: 02-16-16; ASC X12: 02-16-16)

The A/B MAC (A), (B), or (HHH), or DME MAC will fully document and send to the HMO inquiries concerning problems with HMO data on the HI Master. The HMO will resolve the problem and advise the contractor of the results.

30.22 - Provider Problems Obtaining Entitlement Information
(Rev. 3441, Issued: 01-15-16, Effective; 12-31-13; ASC X12: 01-01-12, MAC Implementation: 02-16-16; ASC X12: 02-16-16)

If after application of the above procedures, the provider encounters significant problems in obtaining information regarding Medicare entitlement or benefits in order to accurately prepare bills, the provider should contact the A/B MAC (A), (B), or (HHH), or DME MAC for assistance. However, these requests should be on a non-routine basis. The MAC will assist providers in obtaining entitlement information. The MAC may temporarily refuse assistance if a pattern of abuse is discovered. Situations that may require MAC assistance are:

- When the patient dies following admission. It may be necessary to file timely with an estate;

- When the patient is not in a physical or mental condition to discuss his/her entitlement, and no other person with knowledge of the patient's affairs is available;

- When the provider has reason to believe the beneficiary may need lifetime reserve days, and his/her signature must be obtained if the available lifetime reserve days are not to be used for this admission and other financial arrangements must be made;

- When it is suspected that the beneficiary may have exhausted his/her Medicare benefits, and timely confirmation is needed in order to file for possible supplemental benefits; and

- When the patient has experienced repeated admissions during the same spell of illness, and determining available benefits for the beneficiary is difficult.

50 - Critical Case Procedures - Establishing Entitlement Under Part A and B
(Rev. 1, 10-01-03)

See Chapter 27.

60 - Reserved
(Rev. 3441, Issued: 01-15-16, Effective; 12-31-13; ASC X12: 01-01-12, MAC Implementation: 02-16-16; ASC X12: 02-16-16)

60.1 - Reserved
(Rev. 3441, Issued: 01-15-16, Effective; 12-31-13; ASC X12: 01-01-12, MAC Implementation: 02-16-16; ASC X12: 02-16-16)

60.2 - Reserved
(Rev. 3441, Issued: 01-15-16, Effective; 12-31-13; ASC X12: 01-01-12, MAC Implementation: 02-16-16; ASC X12: 02-16-16).

70 - SSO Assistance in Resolving Entitlement Status Problems
(Rev. 4247, Issued: 03-01-19, Effective: 04-01-19, Implementation: 04-01 -19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

A. Social Security Office (SSO) Assistance

The A/B MAC (A), (B), or (HHH), or DME MAC directs initial requests for assistance to the SSO if the problem is caused by difficulties in determining the beneficiary's correct entitlement status. Examples of situations that may require SSO assistance are:

- Problems involving Railroad Retirement Board (RRB) jurisdiction;

- Evidence that a beneficiary has utilization under more than one Medicare beneficiary identifier but there is no awareness of any cross-reference action taken by CMS; or

- The beneficiary's name, address, sex code, date of birth, or date of death is incorrect on the HI master record.

In the event the SSO is unable to resolve the entitlement problem (e.g., cross referencing of HI records), the MAC requests assistance from the RO.

90 - Outpatient Hospital Registration Procedures
(Rev. 1, 10-01-03)
HO-350

90.1 - Patient Identification
(Rev. 4247, Issued: 03-01-19, Effective: 04-01-19, Implementation: 04-01 -19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

Upon registration of a Medicare beneficiary, or as soon thereafter as practical, the hospital will ask the patient for his/her health insurance card to obtain the Medicare beneficiary identifier. If the patient is unable to provide it, the hospital will contact the SSO for assistance.

90.2 - Determining Whom to Bill
(Rev. 1, 10-01-03)
HO-350.B

The procedures for determining whether another payer exists are the same for outpatient situations as for inpatient. Therefore, the hospital will follow §20 for developing other coverage.

90.3 - Source of Admission - Outpatient Hospital
(Rev. 1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)

The hospital's registration process must distinguish whether the referral source for this registration/admission is from:

- Its own inpatient hospital;

- An encounter in another hospital (see §90.6 for definition of encounter); or

- Any other source - See chapter 25.

Hospitals must determine the appropriate source of admission from internal records or by asking the patient who referred him/her, and whether the referral took place as a result of an encounter in the servicing hospital, another hospital, or elsewhere.

The following coding must be used on the outpatient claim. Therefore admission/registration processes must obtain the information.

1. Physician Referral - The patient was referred to this facility for outpatient or referenced diagnostic services by his/her personal physician, or the patient independently requested outpatient services (self-referral).

2. Clinic Referral - The patient was referred to this facility for outpatient or referenced diagnostic services by this facility's clinic or other outpatient department physician.
3. HMO Referral - The patient was referred to this facility for outpatient or referenced diagnostic services by an HMO physician.

4. Transfer from a Hospital - The patient was referred to this facility for outpatient or referenced diagnostic services by a physician of another acute care facility.

5. Transfer from a SNF - The patient was referred to this facility for outpatient or referenced diagnostic services by a physician of the SNF where the patient is an inpatient.

6. Transfer from Another Health Care Facility - The patient was referred to this facility for outpatient or referenced diagnostic services by a physician of another health care facility where the patient is an inpatient.
7. Emergency Room - The patient was referred to this facility for outpatient or referenced diagnostic services **by** this facility's emergency room physician.

8. Court/Law Enforcement -The patient was referred to this facility for outpatient or referenced diagnostic services upon the direction of a court of law, or upon the request of a law enforcement agency representative.

9. Information not available.

10. Transfer from a CAH - The patient was referred to this facility for outpatient or referenced diagnostic services by (a physician of) the CAH were the patient is an inpatient.

The hospital must determine the proper source of admission code based on the patient's response and/or any other information the hospital may have available from its preregistration records or scheduling data. The hospital must enter the proper source of admission code on the claim.

NOTE: Information regarding the form locator number that corresponds to the source of admission code and a table to crosswalk its CMS-1450 form locator to the 837 transaction is found in Chapter 25.

If the patient was referred for services by a physician at:

- This hospital, the hospital enters codes 2 or 7;

- Another hospital, the hospital enters code 4; or

- Some other source, the hospital enters codes 1, 3, 5, 6, 8, 9, or A, as appropriate.

If the hospital is sure the admission source is not from its hospital or another hospital but cannot determine which of the codes apply, the hospital will enter code 1 on Medicare claims. However, incorrect reporting where services were referred by staff at its own hospital or another hospital (codes 2, 4, or 7 are applicable) is considered program abuse and subject to applicable sanctions.

90.4 - Type of Bill
(Rev. 2971, Issued: 05-23-14, Effective: 07-01-14, Implementation, 07-07-14)

To properly bill, hospitals other than CAHs assign type of bill (TOB) 13X to all bills for outpatient hospital services and TOB 14X for non-patient (referred) laboratory specimens. A non-patient is defined as a beneficiary that is neither an inpatient nor an outpatient of a hospital, but that has a specimen that is submitted for analysis to a hospital and the beneficiary is not physically present at the hospital.

TOB 14X should only be billed for non-patient lab specimens, which are paid under the clinical laboratory fee schedule at the lesser of the actual charge, the fee schedule amount, or the National Limitation Amount (NLA), (including CAHs and MD Waiver hospitals). Part B deductible and coinsurance do not apply for laboratory tests payable on the laboratory fee schedule.

TOB 14X should no longer be used for referred diagnostic services other than laboratory services.

CAHs should bill TOB 85X for outpatient services (including outpatient labs), and TOB 14X for non-patient laboratory specimen tests.

90.5 - Definition of Diagnostic Services
(Rev. 1, 10-01-03)
HO-350.E

A service is "diagnostic" if it is an examination or procedure to which the patient is subjected, or which is performed on materials derived from a hospital outpatient to obtain information to aid in the assessment of a medical condition or the identification of a disease. Among these examinations and tests are diagnostic laboratory services such as hematology and chemistry, diagnostic x-rays, isotope studies, EKGs, pulmonary function tests, psychological tests, and other tests given to determine the nature and severity of an ailment or injury. Hospitals may determine whether services are diagnostic from their internal systems as appropriate.

90.6 - Definition of Encounter
(Rev. 1, 10-01-03)
HO-350F

The term "encounter" means a direct personal contact in the hospital between a patient and a physician, or other person who is authorized by State law and, if applicable, by

hospital staff bylaws to order or furnish services for diagnosis or treatment of the patient. Direct personal contact does not include telephone contacts between a patient and physician. Nor is the compensation arrangement between the physician and the hospital relevant to whether an encounter has occurred. Patients will be treated as hospital outpatients for purposes of billing for certain diagnostic services that are ordered during or as a result of an encounter that occurred while such patients are in an outpatient status at the hospital. If a Medicare outpatient is referred to another provider or supplier for further diagnostic testing or other diagnostic services as a result of an encounter that occurs in this hospital, the hospital is responsible for arranging with the other entity for the furnishing of services. Hospitals are not required to verify that all ordered services are furnished but only to assure that, when it is necessary to refer a patient to an outside entity, the referral is made to a provider or supplier with which the referring hospital an arrangement. This requirement is necessary to assure that billing for services that are furnished is processed through the servicing hospital.

When a patient has follow-up visits with a physician in the hospital following an initial encounter, each subsequent visit to the physician will be treated as a separate encounter for billing.

100 - Reserved
(Rev. 3441, Issued: 01-15-16, Effective; 12-31-13; ASC X12: 01-01-12, MAC Implementation: 02-16-16; ASC X12: 02-16-16)

100.1 - Reserved
(Rev. 3441, Issued: 01-15-16, Effective; 12-31-13; ASC X12: 01-01-12, MAC Implementation: 02-16-16; ASC X12: 02-16-16)

110 - ESRD Method Selection
(Rev. 1, 10-01-03)

See chapter 8, for instructions for completing the ESRD Method Selection Form.

110.1 - Reserved
(Rev. 3441, Issued: 01-15-16, Effective; 12-31-13; ASC X12: 01-01-12, MAC Implementation: 02-16-16; ASC X12: 02-16-16)

120 - Reserved
(Rev. 3441, Issued: 01-15-16, Effective; 12-31-13; ASC X12: 01-01-12, MAC Implementation: 02-16-16; ASC X12: 02-16-16)

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R12423CP	12/20/2023	Enforcing Billing Requirements for Intensive Outpatient Program (IOP) Services with New Condition Code 92	01/02/2024	13222
R4247CP	03/01/2019	Update to Publication 100-04 Chapters 2, 6, and 18 to Provide Language-Only Changes for the New Medicare Card Project	04/01/2019	11155
R3441CP	01/15/2016	Update to Pub. 100-04, Chapter 02 Admission and Registration Requirements, for Provider Verification of Beneficiary Eligibility and Entitlement	02/16/2016	9457
R2971CP	05/23/2014	July 2014 Update of the Hospital Outpatient Prospective Payment System (OPPS)	07/07/2014	8776
R1472CP	03/06/2008	Update of Institutional Claims References	04/07/2008	5893
R1421CP	01/25/2008	Update of Institutional Claims References – Rescinded and Replaced by Transmittal 1472	04/07/2008	5893
R1257CP	05/25/2007	Important Message From Medicare (IM) and Expedited Determination Procedures for Hospital Discharges	07/02/2007	5622
R980CP	06/14/2006	Changes Conforming to CR 3648 Instructions for Therapy Services - Replaces Rev. 941	10/02/2006	4014
R941CP	05/05/2006	Changes Conforming to CR 3648 Instructions for Therapy Services	10/02/2006	4014
R851CP	02/10/2006	Revisions to Instructions for Contractors Other Than the Religious Nonmedical Health Care Institutions Specialty Contractor Regarding Claims for Beneficiaries with RNCHI Elections	05/11/2006	4218

R795CP	12/30/2005	Redefined Type of Bill 14X For Non-Patient Laboratory Specimens-CR 3835 Manualization	04/03/2006	4208
R001CP	10/01/2003	Initial Publication of Manual	NA	NA

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