

CMS Manual System

Department of Health &  
Human Services (DHHS)

Pub 100-04 Medicare Claims Processing

Centers for Medicare &  
Medicaid Services (CMS)

Transmittal 1275

Date: JUNE 29, 2007

Change Request 5629

Subject: Claims Processing Change for Services Submitted with the Health Professional Shortage Area (HPSA) Modifiers QB or QU for Claims with Dates of Service On or After January 1, 2006

I. SUMMARY OF CHANGES: Medicare will no longer accept claims submitted with the QB or QU modifiers for invalid dates of service.

New / Revised Material

Effective Date: January 1, 2006

Implementation Date: October 1, 2007

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

## II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED-Only One Per Row.

R/N/D

Chapter / Section / Subsection / Title

N/A

## III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2007 operating budgets.

## IV. ATTACHMENTS:

## One-Time Notification

\*Unless otherwise specified, the effective date is the date of service.

## Attachment – One-Time Notification

Pub. 100-04

Transmittal: 1275

Date: June 29, 2007

Change Request: 5629

**SUBJECT: Claims Processing Change for Services Submitted with the Health Professional Shortage Area (HPSA) Modifiers QB or QU for Claims with Dates of Service On or After January 1, 2006**

Effective Date: January 1, 2006

Implementation Date: October 1, 2007

### I. GENERAL INFORMATION

A. Background: Medicare contractors sometimes pay HPSA bonuses based on the submission of modifiers. The QB and QU modifiers were the appropriate modifiers to be submitted for claims with dates of service prior to January 1, 2006. The AQ modifier is the appropriate modifier to be used for dates of service on or after January 1, 2006. Currently, per CMS direction, some contractors allow claims submitted with the QB and QU modifiers with dates of service on or after January 1, 2006 to be submitted and processed, though no bonus payment is made as the correct modifier has not been submitted. Per the Health Insurance Portability and Accountability Act (HIPAA) regulations for transactions and code sets, as found in 45 Code of Federal Regulations (CFR) 160, providers must

include valid codes and modifiers, as derived from the standard transaction code sets, on their incoming claims submitted to Medicare. Therefore, allowing claims with inappropriate modifiers to be accepted into the Medicare claims processing system constitutes a violation of the HIPPA standard transaction code sets.

In order to comply with HIPPA regulations and allow claims to be forwarded successfully to supplemental payers, Medicare will no longer accept claims submitted with the QB or QU modifiers for invalid dates of service. Claims must be submitted with the correct modifiers for the correct dates of service in order to be processed.

B. Policy: This CR does not make any change to current HPSA bonus payment policy.

## II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number

Requirement

Responsibility (place an "X" in each applicable column)

A/

B

MAC

DME

MAC

FI

CARRIER

DMERC

RHHI

Shared-System  
Maintainers

OTHER

FISS

MCS

VMS

CWF

5629.1

Contractors shall no longer follow the instructions for processing of claims with the QB or QU modifiers for invalid dates of service as described in BR 2.2 of CR 3935.

X

X

5629.2

As of the October 1, 2007 implementation

X

X

Number

Requirement

Responsibility (place an "X" in each applicable column)

A/

B

MAC

DME

MAC

FI

CARRIER

DMERC

RHHI

Shared-System  
Maintainers

OTHER

FISS

MCS

VMS

CWF

date of this CR, contractors shall return as unprocessable claim lines submitted with the QB or QU modifiers when submitted for invalid dates of service on or after January 1, 2006.

5629.2.1

Contractors shall follow the instructions in the Medicare Claims Processing Manual, Pub. 100-04, Chapter 1, Section 80.3.2.1.2.A for services submitted with invalid modifiers.

X

X

### III. PROVIDER EDUCATION TABLE

Number

Requirement

Responsibility (place an "X" in each applicable column)

A/

B

MAC

DME

MAC

FI

CARRIER

DMERC

RHHI

Shared-System  
Maintainers

OTHER

FISS

MCS

VMS

CWF

5629.3

A provider education article related to this instruction will be available at <http://www.cms.hhs.gov/MLNMattersArticles/> shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv.

Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.

X

X

#### IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:

Use "Should" to denote a recommendation.

X-Ref

Requirement

Number

Recommendations or other supporting information:

N/A

B. For all other recommendations and supporting information, use this space:

N/A

## V. CONTACTS

Pre-Implementation Contact(s): Leslie Trazzi @ leslie.trazzi@cms.hhs.gov.

Post-Implementation Contact(s): Appropriate Regional Office.

## VI. FUNDING

A. For Fiscal Intermediaries, Carriers, and the Durable Medical Equipment Regional Carrier (DMERC), use only one of the following statements:

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

B. For Medicare Administrative Contractors (MAC), use the following statement:

The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

