CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1491	Date: April 11, 2008
	Change Request 5964

SUBJECT: New Process for Accessing MSN Messages and MSN Message File

I. SUMMARY OF CHANGES: This change request updates the list of MSN messages, moves the MSN message list from the manual to cms.hhs.gov, and places a hyperlink (url) to the MSN message file into chapter 21. Minor updates and deletions were made to MSN instructions.

NEW / REVISED MATERIAL
EFFECTIVE DATE: May 12, 2008
IMPLEMENTATION DATE: May 12, 2008

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	21/Table of Contents
R	21/10.1/General Requirements for the MSN
R	21/10.3.1/General Requirements – MSN
R	21/10.3.5/Title Section of the MSN
R	21/10.3.6/Claims Information Section
R	21/10.3.7/Message Section
R	21/10.3.8/Appeals Section
R	21/10.3.10.1/Intermediary Calculations
R	21/10.3.10.2/Carrier Calculations
R	21/20.6/Appeals Section
R	21/30.1/Intermediary Exhibits
R	21/30.2/Carrier Exhibits
R	21/40/Explanatory and Denial Messages
R	21/50/Categories and Identification Numbers for Approved MSN Messages – English Messages

R	21/90/Spanish Messages

III. FUNDING:

SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):
The Medicare administrative contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. 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.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1491	Date: April 11, 2008	Change Request: 5964

SUBJECT: New Process for Accessing MSN Messages and MSN Message File

Effective Date: May 12, 2008

Implementation Date: May 12, 2008

I. GENERAL INFORMATION

A. Background: Instructions related to the Medicare Summary Notice (MSN) are contained in chapter 21. English and Spanish MSN messages are listed in sections 50 through 120. Currently, in order to develop a new MSN message, or use or revise an existing message, a change request (CR) or Joint Signature Memorandum (JSM) is issued that mandates the use of that message for specific situations. Then, after the mandating CR or JSM is issued, a separate CR is done to manualize the MSN message in chapter 21.

Because the list of MSN messages changes frequently, keeping the list of MSN messages in the manual that is up-to-date and useful presents challenges. Therefore, this CR removes the list of MSN messages from the manual and replaces them with a hyperlink: www.cms.hhs.gov/MSN. This hyperlink leads to the MSN page on cms.hhs.gov where the MSN messages will be housed. This will allow more efficient and timely updates to the MSN messages and will reduce the number of CRs overall. All MSN messages still require a mandating CR or JSM, however, once that CR or JSM is issued, the MSN message file on cms.hhs.gov will be updated concurrently thereby eliminating the need for a CR to manualize the MSN message. Contractors are still required to adhere to all sections of chapter 21.

This CR updates the list of MSN messages, moves the MSN message list from the manual to cms.hhs.gov, and places a hyperlink: www.cms.hhs.gov/MSN to the MSN message file into chapter 21, in Sections 50 and 90.

This CR also does the following:

- Places the Prevention Messages that were inadvertently omitted from CR 5799 in section 50.38, the General Information Section, message 38.11, back into message section 50.38.
- Corrects the text of certain Spanish Prevention Messages in the General Information Section – specifically 38.6, 38.7, 38.8 and 38.9.
- Changes the term “DMERC” to “DME MAC” throughout chapter 21 and in messages 8.55 and 11.5.
- Provides Spanish Translations for MSN messages 8.55, 8.57, 8.58, 11.11 and 18.7.
- Corrects the term “PEER Review Organization” as issued in CR 5799 and changes it to “Quality Improvement Organization” in English messages 15.9, 31.6 and 16.4. Spanish translations are correct.
- Removes expired message 60.15.
- Clarifies numbering of message 38.22 according to the Business Requirements of CR 5841.
- Standardizes language in English messages 18.7, 38.7 and 38.8 and Preventive Messages to refer to “Pap test” instead of “Pap smear.” The Spanish translation is still correct.
- Revises references to MSN message sections in the text of chapter 21.
- Removes hyperlinks from other sections of chapter 21 that point to specific MSN messages.
- Changes outdated references to the “EOMB” to “MSN.”

- This CR requires contractors to review all messages listed in the attached message file, and provide comments on each MSN message regarding the related CR number, and the start and stop date, to the extent possible.

Chapter 21 manual sections are attached to this CR. In addition, the complete MSN message file that will be posted on cms.hhs.gov is also attached to this CR.

NOTE: All requests for new or revised MSN messages and questions related to MSNs should be sent to MSN@cms.hhs.gov.

B. Policy: N/A

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
5964.1	Contractors and shared-system maintainers shall be aware that the MSN messages formerly listed in sections 50 through 120 of chapter 21 will be placed in a file on cms.hhs.gov.	X	X	X	X	X	X	X	X		
5964.2	Contractors and shared-system maintainers shall be aware that the hyperlink to the MSN message file on cms.hhs.gov is now in sections 50 (English Messages) and 90 (Spanish Messages). Hyperlinks to sections 50 through 120 of chapter 21 have been removed from the text of the chapter and references to the message sections have been revised.	X	X	X	X	X	X	X	X		
5964.3	Contractors and shared-system maintainers shall be aware that the term "DMERC" has been changed to "Durable Medical Equipment Medicare administrative contractor (DME MAC)" throughout chapter 21.	X	X	X	X	X	X	X	X		
5964.4	Contractors and shared-system maintainers shall be aware that the following prevention messages were inadvertently omitted from CR 5799 and should be included in the MSN message file, General Information Section 38, message 38.11: Preventive Messages: **January - Cervical Health** January is cervical health month. The Pap test is the most effective way to screen for cervical cancer. Medicare helps pay for screening Pap tests every 2 years. For more information on Pap tests, call your Medicare carrier.	X	X	X	X	X	X	X	X		

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	January – National Glaucoma Awareness Month (Optional) Glaucoma may cause blindness. Medicare helps pay for a yearly dilated eye exam for people at high risk for Glaucoma. African-Americans over 50 and people with diabetes or a family history of glaucoma are at higher risk. Talk to your doctor to learn if this exam is right for you. **February –General Preventive Services** Medicare helps pay for many preventive services including flu and pneumococcal shots, tests for cancer, diabetes monitoring supplies and others. Call 1-800-MEDICARE (1-800-633-4227) for more information. **March – National Colorectal Cancer Awareness Month** Colorectal cancer is the second leading cancer killer in the United States. Medicare helps pay for colorectal cancer screening tests. Talk to your doctor about screening options that are right for you. **April - General Preventive Services** Medicare helps pay for many preventive services including flu and pneumococcal shots, tests for cancer, diabetes monitoring supplies and others. Call 1-800-MEDICARE (1-800-633-4227) for more information. **May – National Osteoporosis Month** Do you know how strong your bones are? Medicare helps pay for bone mass measurement tests to measure the strength of bones for people at risk of osteoporosis. Talk to your doctor to learn if this test is right for you. **May - Breast Cancer Awareness (to coordinate with Mother's Day) - Optional** Early detection is the best protection from breast cancer. Get a mammogram. Not just once, but for a lifetime. Medicare helps pay for screening mammograms. **June - General Preventive Services Message**										

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
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	Medicare helps pay for many preventive services including flu and pneumococcal shots, tests for cancer, diabetes monitoring supplies and others. Call 1-800-MEDICARE (1-800-633-4227) for more information. **July- Glaucoma Awareness** Glaucoma may cause blindness. Medicare helps pay for a yearly dilated eye exam for people at high risk for Glaucoma. African-American people over 50, and people with diabetes or a family history of glaucoma are at higher risk. Talk to your doctor to learn if this exam is right for you. **August - National Immunization Awareness Month** (Contractors may elect to print this message during a different month of their choosing, but the message about the pneumococcal shot must be printed one month of each year.) Get a pneumococcal shot. You may only need it once in a lifetime. Contact your health care provider about getting this shot. You pay nothing if your health care provider accepts Medicare assignment. **September - Cold and Flu Campaign** During this flu season, get your flu shot. Contact your health care provider for the flu shot. Get the flu shot, not the flu. You pay nothing if your health care provider accepts Medicare assignment. **September - Prostate Cancer Awareness Month - Optional** Prostate cancer is the second leading cause of cancer deaths in men. Medicare covers prostate screening tests once every 12 months for men with Medicare who are over age 50. **October – Breast Cancer Awareness Month** Early detection is your best protection. Schedule your mammogram today, and remember that Medicare helps pay for screening mammograms. **October – Continuation of Cold/Flu Campaign (optional)**										

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	If you have not received your flu shot, it is not too late. Please contact your health care provider about getting the flu shot. **November - American Diabetes Month** Medicare covers benefits to help control diabetes. Benefits include screenings to check for diabetes, your diabetes self-testing equipment and supplies, diabetes self-management training and medical nutrition therapy. **November – Continuation of Cold/Flu Campaign** If you have not received your flu shot, it is not too late. Contact your health care provider about getting the flu shot. **December –** See BR 5964.5 The related Spanish messages should read: **January** Enero es el mes de la prevención del cáncer cervical. La prueba de papanicolao (o prueba pap) es la manera más efectiva de examinar el cáncer cervical. Medicare ayuda a pagar por la prueba de papanicolao (o prueba pap) una vez cada dos años. Para más información sobre el examen papanicolao, llame a su agencia de seguros Medicare. El glaucoma puede provocarle ceguera. Medicare paga una parte del examen de dilatación ocular para aquellas personas con riesgo a padecer de glaucoma. Los afroamericanos de 50 años o más así como las personas diabéticas o con historial familiar de glaucoma son considerados de alto riesgo. Hable con su médico para averiguar si tiene que hacerse este examen. **February** Medicare le ayuda a pagar por muchos servicios preventivos como la vacuna contra la gripe y la neumocócica, las pruebas de cáncer, el monitoreo y suministros para diabéticos y otros. Si desea más										

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	información, llame GRATIS al 1-800-MEDICARE (1-800-633-4227). **March – National Colorectal Cancer Awareness Month** El cáncer colorrectal es la segunda causa de muerte en los Estados Unidos. Medicare le ayuda a pagar por el examen de detección de cáncer colorrectal. Hable con su médico para averiguar si tiene que hacerse este examen. **April - General Preventive Services** Medicare le ayuda a pagar por muchos servicios preventivos como la vacuna contra la gripe y la neumocócica, las pruebas de cáncer, el monitoreo y suministros para diabéticos y otros. Si desea más información, llame GRATIS al 1-800-MEDICARE (1-800-633-4227). **May – National Osteoporosis Month** ¿Sabe usted qué tan fuerte son sus huesos? Medicare le ayuda pagar por la prueba de medición de masa ósea (densitometría) para las personas a riesgo de padecer de osteoporosis. Hable con su médico para averiguar si tiene que hacerse esta prueba. **May - Breast Cancer Awareness (to coordinate with Mother's Day) – Optional** La detección temprana es su mejor protección contra el cáncer de mamas. Haga una cita para una mamografía. No lo haga por única vez sino por el resto de su vida. Medicare cubre las mamografías. **June - General Preventive Services Message** Medicare le ayuda a pagar por muchos servicios preventivos como la vacuna contra la gripe, y la neumocócica, las pruebas de cáncer, el monitoreo y suministros para diabéticos y otros. Si desea más información, llame GRATIS al 1-800-MEDICARE (1-800-633-4227). **July- Glaucoma Awareness**										

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	El glaucoma puede provocarle ceguera. Medicare paga una parte del examen de dilatación ocular para aquellas personas con riesgo a padecer de glaucoma. Los afroamericanos de 50 años o más así como las personas diabéticas o con historial familiar de glaucoma son considerados de alto riesgo. Hable con su médico para averiguar si tiene que hacerse este examen. **August - National Immunization Awareness Month** (Contractors may elect to print this message during a different month of their choosing, but the message about the pneumococcal shot must be printed one month of each year.) Aplíquese la vacuna neumocócica. Tal vez la necesite una sola vez en su vida. Hable con su médico acerca de esta vacuna. Usted no tiene que pagar por la vacuna neumocócica si su proveedor acepta la asignación. **September - Cold and Flu Campaign** Durante la época de gripe, vacúnese. Hable con su médico acerca de esta vacuna. Combata la gripe en lugar de contraerla. Usted no tiene que pagar por la vacuna antigripal si su proveedor acepta la asignación. **September - Prostate Cancer Awareness Month - Optional** El cáncer de la próstata es la segunda causa de muerte entre los hombres. Medicare cubre el examen para la detección de cáncer de la próstata cada 12 meses para los beneficiarios de Medicare de 50 años o mas. **October – Breast Cancer Awareness Month** La detección temprana es su mejor protección contra el cáncer de los senos. Haga una cita para una mamografía hoy, recuerde que Medicare paga por este examen. **October – Continuation of Cold/Flu Campaign (optional)** Si aún no ha recibido la vacuna contra la gripe, todavía está a tiempo. Hable con su médico para que le aplique la										

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	vacuna. **November - American Diabetes Month** Medicare cubre beneficios para el control de la diabetes. Entre ellos se incluyen el equipo y suministros para el examen de azúcar en sangre, el entrenamiento para el autocontrol de la diabetes y la terapia de nutrición. **November – Continuation of Cold/Flu Campaign** Si aún no ha recibido la vacuna contra la gripe, todavía está a tiempo. Hable con su médico para que le aplique la vacuna. **December** - See BR 5964.5										
5964.5	Contractors and shared system maintainers shall be aware of the following change to the December Preventive MSN Message in the General Information section at 38.11: **December – New Preventive Benefits** Medicare covers cardiovascular screenings that check your cholesterol and other blood fat levels and screenings to check for diabetes. Talk to your doctor or call 1-800-MEDICARE (1-800-633-4227) for more information. **December – New Preventive Benefits** Medicare cubrirá los exámenes cardiovasculares para medir el colesterol y los lípidos, así como las pruebas para el control de la diabetes. Si desea más información, hable con su médico o llame al 1-800-MEDICARE (1-800-633-4227).	X	X	X	X	X	X	X	X		
5964.6	Contractors and shared system maintainers shall be aware that the text for the following Spanish MSN messages should be corrected as follows: 38.6 January is cervical cancer prevention month. 38.6 Enero es el mes de la prevención del cáncer cervical.	X	X	X	X	X	X	X	X		

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	38.7 The Pap test is the most effective way to screen for cervical cancer. 38.7 La prueba de papanicolao (o prueba pap) es la manera más efectiva de examinar el cáncer cervical. 38.8 Medicare helps pay for screening Pap tests once every two years. 38.8 Medicare ayuda a pagar por la prueba de papanicolao (o prueba pap) una vez cada dos años. 38.9 Colorectal cancer is the second leading cancer killer in the United States. However, screening tests can find polyps before they become cancerous. They can also find cancer early when treatment works best. Medicare helps pay for screening tests. Talk to your doctor about the screening options that are right for you. 38.9 El cáncer colorectal es el segundo cáncer principal que ataca en los E.E.U.U. Sin embargo, pruebas de investigación pueden encontrar pólipos antes de que lleguen a ser cancerosos. También pueden encontrar el cáncer temprano cuando el tratamiento trabaja lo mejor posible. Medicare ayuda a pagar por pruebas de investigación. Comuníquese con su doctor sobre las opciones de pruebas de investigación que son apropiadas para usted.										
5964.7	Contractors and shared system maintainers shall change the text of messages 8.55 and 11.5 from "DMERC" to "Durable Medical Equipment Medicare Administrative Contractor (DME MAC)" as shown below: 8.55 Medicare will process your first claim only. In the future, you must use a Medicare enrolled supplier and provide the supplier identification number on your claim. For a listing of enrolled Medicare suppliers, contact your local Durable Medical Equipment Medicare Administrative Contractor (DME MAC).	X	X	X	X	X	X	X	X		

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	For the Spanish translation of 8.55, see BR 5964.8 11.5 This claim will need to be submitted to (another carrier, a durable medical equipment medicare administrative contractor (DME MAC), or Medicaid agency). 11.5 Esta reclamación debe ser sometida a (otra agencia de seguros de Medicare Parte B, agencia regional de seguros para equipo médico duradero (DME MAC) o una agencia de Medicaid).										
5964.8	Contractors and shared system maintainers shall be aware of the additions of Spanish translations for the following MSN messages: 8.55 Medicare will process your first claim only. In the future, you must use a Medicare enrolled supplier and provide the supplier identification number on your claim. For a listing of enrolled Medicare suppliers, contact your local durable medical equipment medicare administrative contractor (DME MAC). 8.55 Medicare procesará solamente su primera reclamación. En el futuro, usted debe usar un proveedor inscrito en Medicare y debe proporcionar en la reclamación el número de identificación del proveedor. Si desea una lista de proveedores inscritos en Medicare, comuníquese con el Contratista Administrativo de Medicare para Equipo Médico duradero (DME MAC). 8.57 Your equipment supplier must furnish and service this item for as long as you continue to need it. Medicare will pay for maintenance and/or servicing for every 3 month period after the end of the 15th paid rental month. 8.57 Su proveedor debe proporcionarle el equipo y el mantenimiento del mismo por todo el tiempo que usted lo necesite. Medicare pagará por el mantenimiento y arreglos cada tres meses después del mes número 15 de los pagos por el alquiler del equipo.	X	X	X	X	X	X	X	X		

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	8.58 No payment can be made because the item has reached the 15 month limit. Separate payments can be made for maintenance or servicing every 3 months. 8.58 No se puede hacer un pago por este artículo ya que alcanzó el límite de 15 meses. Se pueden hacer pagos separados para el mantenimiento del equipo cada tres meses. 11.11 This claim/service is not payable under our claims jurisdiction. We have notified your provider to send your claim for these services to the United Mine Workers of America for processing. 11.11 Esta reclamación no puede pagarse en nuestra jurisdicción de reclamaciones. Ya le informamos a su proveedor que debe mandar la reclamación a United Mine Workers of America para que procesen el pago. 18.7 Screening pap tests are covered only once every 24 months unless high risk factors are present. 18.7 El examen Papanicolaou está cubierto cada 24 meses a menos que se detecten factores de alto riesgo.										
5964.9	Contractors and shared system maintainers shall be aware that the term "PEER Review Organization" should read "Quality Improvement Organization" as noted in the text of the following MSN messages: 15.9 The quality improvement organization did not approve this service. 16.4 This service requires prior approval by the quality improvement organization. 31.6 A payment adjustment was made based on a quality improvement organization request. The Spanish translations of these messages are accurate.	X	X	X	X	X	X	X	X		

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
5964.10	Contractors and MACs shall no longer print the following expired MSN messages: 60.15- Beginning April 1, 2005 through March 31, 2007, Medicare will cover additional chiropractic services. For more information, talk to your chiropractor, call 1-800-MEDICARE, or go to http://www.cms.hhs.gov/researchers/demos/eccs/default.asp. 60.15- Comenzando el 1 de abril de 2005 hasta el 31 de marzo de 2007, Medicare cubrirá más servicios quiroprácticos. Para más información, comuníquese con su quiropráctico, llame al 1-800-MEDICARE o visite el sitio de Internet http://www.cms.hhs.gov/researchers/demos/eccs/default.asp	X	X	X	X	X	X	X	X		
5964.11	Contractors and shared systems maintainers shall be aware of the following clarification to CR 5841. MSN message 38.21 has expired. Message 38.22 was incorrectly numbered as 38.21 in the manual section and should be numbered 38.22 as stated in the Business Requirements of CR 5841. This message reads: 38.22 Planning to retire? Does your current insurance pay before Medicare pays? Call Medicare within the six months before you retire to update your records. Make sure your health care bills get paid correctly. 38.22 ¿Está planificando retirarse? ¿Su actual seguro de salud paga antes que Medicare? Favor de llamar a Medicare 6 meses antes que piensa retirarse para actualizar la información de su expediente. Asegúrese que sus facturas médicas se paguen correctamente.	X	X	X	X	X	X	X	X		
5964.12	Contractors and shared systems maintainers shall be	X	X	X	X	X	X	X	X		

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	aware that the text of MSN message 35.3 should include the words "submitted on the claim" and read as follows: 35.3 A copy of this notice will not be forwarded to your Medigap insurer because the information submitted on the claim was incomplete or invalid. Please submit a copy of this notice to your Medigap insurer. 35.3 No se enviará copia de esta notificación a su asegurador de Medigap debido a que la información estaba incompleta o era inválida. Favor de someter una copia de esta notificación a su asegurador Medigap.										
5964.13	Contractors and shared systems maintainers shall be aware that the text of MSN message 18.7 has been revised from "Screening pap smears" to the following: 18.7 Screening pap tests are covered only once every 24 months unless high risk factors are present. The Spanish translation remains: 18.7 El examen Papanicolaou está cubierto cada 24 meses a menos que se detecten factores de alto riesgo.	X	X	X	X	X	X	X	X		
5964.14	Contractors and shared systems maintainers shall be aware of the following text change to MSN message 16.57. 16.57 Medicare Part B does not pay for this item or service since our records show that you were in a Medicare health plan on this date. Your provider must bill this service to the Medicare health plan. 16.57 La Parte B de Medicare no paga por este artículo o servicio ya que nuestros expedientes muestran que en esta fecha usted estaba en un plan de salud de Medicare. Su proveedor debe facturar este servicio a el plan de salud de Medicare.	X	X	X	X	X	X	X	X		

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
5964.15	This CR requires contractors to review all messages listed in the attached MSN message file and provide comments on each MSN message regarding the related CR number and the start and stop date, to the extent possible.	X	X	X	X	X	X	X	X		

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	None.										

IV. SUPPORTING INFORMATION: N/A

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

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

V. CONTACTS

Pre-Implementation Contact(s): Jeannie Wilkerson (Jeannie.Wilkerson@cms.hhs.gov) or Eileen Zerhusen (Eileen.Zerhusen@cms.hhs.gov).

Post-Implementation Contact(s): Jeannie Wilkerson (Jeannie.Wilkerson@cms.hhs.gov) or Eileen Zerhusen (Eileen.Zerhusen@cms.hhs.gov).

VI. FUNDING

A. *For Fiscal Intermediaries and Carriers*:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

B. *For Medicare Administrative Contractors (MAC)*:
The Medicare administrative contractor (MAC) is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as changes to the MAC Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts specified 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.

Medicare Claims Processing Manual

Chapter 21 - Medicare Summary Notices

Table of Contents
(Rev.1491, 04-11-08)

10.1 - General Requirements for the MSN

(Rev.1491, Issued: 04-11-08, Effective: 05-12-08, Implementation: 05-12-08)

A. Intermediary/RHHI MSN

The MSN is used to notify Medicare beneficiaries of action taken on intermediary processed claims. MSNs are not used by RHHIs for RAPs, and RAP data are not included on the monthly MSN.

The MSN provides the beneficiary with a record of services received and the status of any deductibles. The MSN also informs the beneficiary of appeal rights. The Balanced Budget Act of 1997 requires all Part A benefit notices to include the amount of Medicare payment for each service. Intermediaries and carriers (including RHHIs and *DME MACs)* must furnish an MSN to all beneficiaries for whom claims are filed during the month unless the situation is specifically excluded by other manual instructions. Contractors shall issue No-Pay MSNs on a quarterly/90 day mailing cycle. MSNs with a payment check to the beneficiary shall continue to be mailed out as processed. No–pay MSNs are defined as those MSNs which do not require payment to the beneficiary for the respective claim(s).

The MSN replaced the following documents:

- Form CMS-1533, Part A Medicare Benefit Notice, also known as the Part A Notice of Utilization (NOU) sent for inpatient services;
- Form CMS-1954, Benefit Denial Letter (BDL), sent for partially denied claims; and
- Form CMS-1955, BDL sent for totally denied claims.

Since CMS eliminated BDLs, Medicare beneficiaries receive the information previously conveyed on BDLs through narrative messages contained on the MSN. Providers no longer receive a separate written notification or copy of the BDL. Providers must utilize the coding information (e.g., ANSI Reason Codes) conveyed on the financial remittance advice to ascertain reasons associated with Medicare claims determinations affecting payment and applicable appeal rights and/or appeals information.

B. Carrier/*DME MAC MSN*

The MSN is used to notify Medicare beneficiaries of action taken on their processed claims. The MSN provides the beneficiary with a record of services received and the status of any deductibles. The MSN also informs the beneficiary of appeal rights.

10.3.1 - General Requirements - MSN

(Rev.1491, Issued: 04-11-08, Effective: 05-12-08, Implementation: 05-12-08)

The MSN is specifically designed as a summary notice to beneficiaries. Providers receive a summary voucher and check. Intermediaries send MSN notices to beneficiaries for outpatient and inpatient claims combined in one notice. Contractors shall issue No-Pay MSNs on a quarterly/90 day mailing cycle. MSNs with payment checks to the beneficiary shall continue to be mailed out as processed. No–pay MSNs are defined as those MSNs which do not require payment to the beneficiary for the respective claim(s).Carriers send notices for unassigned claims and assigned claims with payment due to the beneficiary as they are processed or according to their present schedule.

When requested by the quality assurance (QA) staff, contractors produce an exact copy of the MSN sent to the beneficiary for QA reviews. If the beneficiary requests a replacement copy, the contractor must be able to produce an exact copy as it was originally generated or produce an MSN containing only the claim requested by the beneficiary, even though it may have been part of a summary. The beneficiary's request will determine the type of copy that the contractor sends.

Copies for claims processed prior to the MSN format can be produced in the MSN format. Contractors must also generate an MSN upon beneficiary request for previously suppressed claim information.

Contractors must have the capability to issue the MSN in Spanish, if the beneficiary requests this. To assess beneficiary preference for a Spanish MSN, contractors may print a message in the General Information section in both Spanish and English, which tells beneficiaries that they can receive the MSN in Spanish if they desire.

Contractors also:

Generate by computer the entire front of the form; and

Preprint or generate by computer the back of the form.

To the extent that contractors have the capability to perform duplex printing, they must exercise that option.

To ensure all claims processing messages are uniform throughout the Medicare program, contractors do not use locally developed claims processing messages until approved and assigned a number by central office. Contractors send draft claims processing messages for preliminary review to their RO along with an explanation of necessity. Regional offices now have the authority to approve local General Information and "Help Stop Fraud" messages.

Carriers and intermediaries are required to include a "Help Stop Fraud" message every 6 months.

Language must be approved by the RO. Contractors send draft messages for review to their RO along with an explanation of necessity. The RO will review the messages and respond.

The "*Be Informed*" section is designed for varying "Help Stop Fraud" messages, which can be found *at the url in §50 of this chapter, message section 24 ,* and/or to alert beneficiaries of local fraud scams. For example, if a contractor knows of someone offering free cheese and milk in exchange for Medicare numbers, it can design a message telling beneficiaries to be extra careful. Since space is limited in the "*Be Informed*" section, the contractor can use the "General Information" section for lengthy messages. If it uses those messages provided in *§50, message section 24*, it should review its message every 6 months to determine if a more appropriate message could be used. "Help Stop Fraud" messages may be changed as often as necessary, as long as they are timely and current. Messages that pertain to local fraud scams need only be approved at the RO level. General "Help Stop Fraud" messages that contractors develop, similar in content to those listed in §50, *message section 24*, must be approved by CMS.

The "General Information" section is designed to inform beneficiaries of local health fairs and Medicare seminars, as well as the *"Help Stop Fraud" messages*, and those mandated by CMS. Messages that pertain to local events need be approved only at the RO level. "General Information" messages that carriers develop, similar in content to those listed in §50, *message section 24*, must be approved by CO through the RO.

Sample exhibits are provided in *§30*. These samples are referenced throughout the text. In the event of a discrepancy, the written instructions take precedence over the exhibits.

10.3.5 - Title Section of the MSN

(Rev.1491, Issued: 04-11-08, Effective: 05-12-08, Implementation: 05-12-08)

A. General Information About the "Title" Section

This section contains a fixed display of information. It does not vary in length. It contains the following elements:

- Title of notice;
- Beneficiary name and mailing address;
- "Be Informed" statement; and
- Customer Service Information including:

    ° Beneficiary Medicare number – In order to protect a beneficiary's PHI, contractors shall replace the first five numerics of the HICN with "X's" on all Medicare Summary Notices at the time they are printed. This requirement applies to pay, no-pay, and duplicate copies of the MSN.

- BCC mailing address and contractor ID number
- 1-800-MEDICARE (1-800-633-4227)
- TTY telephone number;
- "Summary of Claims Processed" statement.

NOTE: Contractors have the option of changing the type of information in the Customer Service Information box. For example, they may or may not choose to list the Suite number in the address. At a minimum, however, they must still include the BCC address, the contractor ID number, 1-800-MEDICARE (1-800-633-4227), and the national TTY number (1-877-486-2048). There must be one blank line between the address and phone numbers. All changes must be approved by each contractor's RO. The RO will notify CO of the approved change.

Contractors, A/B MACs, and DME MACs should have a Customer Service Information Box that resembles the example below. Continue to follow the existing instructions regarding which IVR prompting statement to print in the CS Information box. For example, Part A MSNs should state "Ask for Hospital Services, B- Ask for Doctor's services and D- Ask for medical supplies.

EXAMPLE:

CUSTOMER SERVICE INFORMATION

Your Medicare Number: 111-11-1111A
If you have questions, write or call 1-800 MEDICARE
(1-800-633-4227) (#12345)

Ask for Hospital Services
TTY for hearing impaired: 1-877-486-2048

B. Technical Specifications for "Title" Section

Details of the technical specifications for each element in the title section follow.

Title of Notice

"Medicare Summary Notice" is printed in mixed case equivalent to 30-point bold type. The title is centered within a box of 10-percent shading. The box extends from left margin to right margin. In the left corner of the box, the CMS logo (imported) is printed. In the upper right hand corner of box "Page 1 of __" is printed in mixed case equivalent to 10-point type.

In the bottom right hand corner of the title box, the date the notice was printed is shown in mixed case equivalent to 10-point type.

Then a blank line equivalent to 10-point type occurs.

Beneficiary Name and Mailing Address

The beneficiary name, mailing address, and dollar amounts are printed in all uppercase letters equivalent to 10-point size fixed pitch font (the font may not be script, italic or any other stylized font). The name and address information is placed as shown in exhibits to conform to U. S. postal regulations. (The beneficiary name, mailing address, and dollar amounts are the only data elements that may be printed in fixed pitch fonts. The rest of the MSN is printed using proportional fonts.)

Contractors are not to change the format of the "Title" section in order to use double window envelopes. Include a separate mailing sheet with both a return and delivery address for double window envelopes.

Customer Service Information (refer to note in A above)

Print a box equivalent to a 1-point line around the following customer service information. Extend from center of page to the right margin. Height is 2 1/2 inches. Width is 3 1/2 inches.

- Allow equivalent to 12-point blank line.

- Print "Customer Service Information" in upper case equivalent to 12-point bold type.

- Print "Your Medicare Number: _____" centered in the box equivalent to 12-point bold mixed case.

- Print the appropriate contractor ID number. The ID number should be preceded by the number sign, and both the number sign and the ID number should be enclosed in parentheses and printed in bold-faced type (if possible).

INTERMEDIARIES ONLY:

- Indent 4 bytes and print "Call:" then "1-800-MEDICARE (1-800-633-4227)", in mixed case (print MEDICARE in uppercase) equivalent to 12-point bold type.

- Indent 4 bytes and print "Ask for Hospital Services" in mixed case equivalent to 12-point bold type

- Indent 4 bytes and print "TTY for Hearing Impaired:" then "1-877-486-2048" in mixed case equivalent to 12-point type.

CARRIERS ONLY:

- Indent 4 bytes and print: "Call:" then "1-800-Medicare (1-800-633-4227)", in mixed case (print MEDICARE in uppercase) equivalent to 12-point bold type.

- Indent 4 bytes and print “Ask for Doctor Services” in mixed case equivalent to 12-point bold type.

- Indent 4 bytes and print “TTY for Hearing Impaired:” then “1-877-486-2048” in mixed case equivalent to 12-point type.

DME *MACs* ONLY:

- Indent 4 bytes and print: “Call:” then “1-800-Medicare (1-800-633-4227)”, in mixed case (print MEDICARE in uppercase) equivalent to 12-point bold type.

- Indent 4 bytes and print “Ask for Medical Supplies” in mixed case equivalent to 12-point bold type.

- Indent 4 bytes and print “TTY for Hearing Impaired:” then “1-877-486-2048” in mixed case equivalent to 12-point type.

Be Informed Statement

- Print “Be Informed:” in upper case letters and bold equivalent to 12-point type. Begin printing the fraud message on the same line as “Be Informed:” Print the fraud message in mixed case equivalent to 12-point type. It may continue for 2 additional lines. Fraud messages are found *in the MSN file at the hyperlink in §50, message section 24*. Print only those messages approved for the “Be Informed” section. The “Be Informed” section should end no lower than the bottom of the “Customer Service Information” box. There should be at least 2 bytes between the end of each line and the beginning of the “Customer Service” box.

- Allow equivalent to 12-point blank line.

- For intermediaries, on all notices processed for services on multiple days, print “This is a summary of claims processed from mm/dd/yyyy to mm/dd/yyyy.” in mixed case equivalent to 14-point type centered between the margins. For all notices for services processed on a single day, print “This is a summary of claims processed on mm/dd/yyyy.” in mixed case equivalent to 14-point type centered between the margins.

- Allow equivalent to 18-point blank line.

- For carriers, for unassigned and assigned claims with no payment to the beneficiary, and with different finalization dates, print, “This is a summary of claims processed from mm/dd/yyyy through mm/dd/yyyy” in mixed case equivalent to 14-point type centered between the margins.

- For carriers, for unassigned and assigned claims with no payment to the beneficiary and the same finalization dates, print “This is a summary of claims processed

on mm/dd/yyyy in mixed case equivalent to 14-point type centered between the margins."

- For unassigned and assigned claims with payment to the beneficiary, print "This is a summary of claims processed on mm/dd/yyyy in mixed case equivalent to 14-point type centered between the margins. The mm/dd/yyyy inserts should be high/low claim finalization dates." Allow equivalent to 18-point blank line.

10.3.6 - Claims Information Section

(Rev.1491, Issued: 04-11-08, Effective: 05-12-08, Implementation: 05-12-08)

A. General Information About the "Claims Information" Section

The claims information section contains the following elements:

- For Intermediaries:

    - Program Status Line ("Part A Hospital Insurance - Inpatient Claims" or "Part B Medical Insurance - Outpatient Facility Claims" or "Home Health Facility Claims" or "Hospice Facility Claims"

    - Column Heading

    - Claim Number

    - Provider's Name and Address

    - Attending/referring Physician's Name

    - Service Line Details

    - Claims Totals

    - Alphabetic Codes for "Notes"

    - The name and address of the billing provider includes the provider's name and complete address. Below the billing provider's name and address, if applicable, show "referred by the full name of the attending physician.

    - Claims should be displayed by billing provider in alphabetic order.

    - For multiple claims from one billing provider, sort claims chronologically by service.

- Use standard abbreviation of Revenue Codes provider by the National Uniform Billing Committee and do not change wording.

- If HCPCS are shown, use short description of services provided by CMS. If the descriptor is used, do not show the revenue code descriptor.

For Carriers - Part B Medical Insurance:

Except for the header and the provider name(s) and address(es), which are fixed, the data in Area II can vary in length. Area II contains the following elements:

- Control number(s),

- Provider name(s) and address(es),

- Service or line item detail, and

- Alphabetic note codes.

B. Technical Specifications for "Claims Information" Section For Intermediaries:

Program Status Line

- For inpatient claims print "PART A HOSPITAL INSURANCE - INPATIENT CLAIMS" in uppercase equivalent to 12-point bold type;

- For outpatient claims, print "PART B MEDICAL INSURANCE - OUTPATIENT FACILITY CLAIMS" in uppercase equivalent to 12-point bold type;

- For Home Health Part A claims, print "PART A - HOME HEALTH FACILITY CLAIMS";

- For hospice claims, print "Part A - HOSPICE FACILITY CLAIMS."

Allow equivalent to 10-point blank line.

Print a box equivalent to a 1-point line around the following claims information. The box will be variable in length depending on the number of claims displayed. There is a 1-byte margin between the claims information box line and the beginning and ending of printed information. There is a 1-byte space between columns. Print the column headings in mixed case type, equivalent to 10-point bold type, using 3 lines as in the exhibits.

Dates of Service - The "Dates of Service" column is 17 bytes wide. Center the column heading within the first 7 bytes.

Services Provided - Use for outpatient claims only. The “Services Provided” column is 45 bytes wide. Print the column heading flush left in the column.

Number of Services Provided - Use for Home Health claims. The “Number of Services Provided” column is 45 bytes wide. Print the column heading flush left in the column.

Benefit Days Used - Use for inpatient claims only. The “Benefit Days Used” column is 11 bytes wide. Print the column flush right.

Amount Charged - Used for Outpatient and Home Health Claims Only - The “Amount Charged” column is 11 bytes wide. Print the column heading flush right in the column.

Noncovered Charges - The “Noncovered Charges” column is 11 bytes wide. Print the column heading flush right in the column.

Deductible and Coinsurance - Used for Inpatient and Outpatient Claims - The “Deductible and Coinsurance” column is 10 bytes wide. Center the column heading. (For Home Health claims, the title is “Coinsurance").

You May Be Billed - The “You May Be Billed” column is 10 bytes wide. Center the column heading.

See Notes Section - The “See Notes Section” is 7 bytes wide. Center the column heading.

Print a horizontal equivalent to 1-point line extending from left to right margin between the column headings and the claim(s) information.

Allow equivalent to 10-point blank line.

Print claim information within the box as follows:

- The claim number spans the “Dates of Service” and “Services Provided” columns. Do not extend information into the “Amount Charged” column.
    - Print “Claim number” in mixed case equivalent to 10-point mixed case followed by the actual claim number on the line directly above the provider name and address.
- The provider information spans the “Dates of Service” and “Services Provided” columns. Do not extend information into the “Amount Charged” column.
    - Print the billing provider name and mailing address in mixed case equivalent to 10-point bold type. Billing provider name and address should be separated by commas. Use the physical address of the billing provider if it is different from the mailing address. If possible, print this information on one line. Additional lines, if

necessary, should be indented five bytes. For carriers, when using degree (e.g. M.D.) with provider name, place a period after the "M" and after the "D."

- Print "Referred by:" followed by the attending physician's name and degree (if applicable) in mixed case equivalent to 10-point type. When printing degree (e.g., M.D.) with provider name, place a period after the "M" and after the "D." Referring physician name and degree should be separated by a comma. If the UPIN submitted on the claim is not on file, use the name as shown on the claim. Suppress the "Referred by:" line if not able to identify the doctor. For carriers, if the referring physician is the same as any performing physician on the claim, suppress the referring physician line. If the UPIN submitted on the claim is not on the contractor's file, suppress the "Referred by:" line. For clinic or group practice billing, print the performing physician's name in mixed case equivalent to 10-point type immediately before the services the physician performed.

- Dates of Service - Print service line dates in mm/dd/yyyy format in "Dates of Service" column in mixed case equivalent to 10-point type, left justified. If services extend over several days, use a hyphen or dash to show the extension (mm/dd/yyyy - mm/dd/yyyy).

- The "Services Provided" column contains the HCPCS short descriptor in mixed case equivalent to 10-point type followed by code in parenthesis or revenue code descriptor. If no HCPCS code is present, show the revenue code standard abbreviation as defined by the National Uniform Billing Committee, left justified (bytes 1-47 are reserved for these descriptions). Print each service description on no more than 1 line, on the same line horizontally as the date of service.

- Number of Services Provided - The "Number of Services Provided" column is the revenue code standard abbreviation as defined by the National Uniform Billing Committee, preceded by the number of units, both of which are in mixed case to 10 point type. If a HCPCS code is present, the HCPCS short descriptor will be used. Left justify (bytes 1-45 are reserved for this element). Print each "Number of Services Provided" in no more than one line, on the same line horizontally as the "Date of Service."

- Benefit Days Used - This column will show the number of days used during the hospital or skilled nursing facility admission (i.e., 12 days) Use case equivalent to 10 point type. Left justify (bytes 1-11 are reserved for this). Print each "Benefit days Used" in no more than one line on the same line horizontally as "Date of Service."

- Align all dollar amounts appearing in the "Claim Information Box" by decimal. For zero dollar amounts, show "0.00." Print all dollar amounts in mixed case equivalent type.

- Amount Charged - Show the submitted charge for each service line. Print a dollar sign on the first service line. Right justify all charges. This detail is not shown on Part A inpatient (hospital or SNF) claims. Print in mixed case equivalent to 10-point type.

- Noncovered Charges - Show the noncovered amount for each service line. Print a dollar sign on the first service line. Right justify all charges. Noncovered services will include beneficiary liable as well as provider liable charges.

- Deductible and Coinsurance - Show the "Deductible and Coinsurance" applicable for each service line. Print a dollar sign on the first service line. Right justify all amounts. Carriers show deductible and coinsurance with a message in the "Notes" section.

- You May Be Billed - Show the beneficiary liability for each service line. Print a dollar sign on the first service line. Right justify all amounts. Print in mixed case equivalent to 10-point type.

- See Notes Section - Enter lowercase "a" for the first item that requires an explanation. Place "a" and the appropriate message from *§50* in the "See Notes Section" box. If the same message is needed for more than one claim or service line, print the same alphabetic code each time the message is required on the MSN. Print alphabetic codes in mixed case equivalent to 10-point type.

    - If the contractor's system provides a second message for the same item, print the letter "b" in lowercase equivalent to 10-point type preceded by a comma. Show no more than three alphabetic codes per line.

    - For all remaining claims on the MSN, if a claim or service line requires a message, use the next available lowercase alphabetic code.

    - Print alphabetic codes for claim level notes in bold in the "See Notes Section" column on the same line as the billing provider's name. The next 3 codes will be directly below the first 3, which places them on the same line as the billing provider's street address. Print alphabetic codes for service lines in the "See Notes Section" column on the same line as the service. If more than 3 codes for line level, print on the next line below. Print alphabetic codes flush left. If more than 26 lower case alphabetic codes are used, begin using uppercase alphabetic codes.

- Claim Total Line - Indent 12 bytes and print in mixed case type equivalent to 10-point bold "Claim Total." Print the "Claim Total" line only for claims with more than one service line.

    - Total the amounts in each column and print the sum right justified and equivalent to 10-point bold type. Print a dollar sign preceding the total in each column. The total amount in the "Medicare Paid You" column includes all interest paid to the beneficiary for that claim.

- Print a horizontal line 1/16-inch wide in 20 percent shading extending from left to right margin on the claim information box. Print this shaded line between each claim shown on the MSN. Do not print the shaded line under the last claim displayed in the

"Claims Information Section." Do not print the shaded line if only one claim is displayed on the MSN.

For Carriers:

Carriers print in the following order:

1. Horizontal line (0.048" wide extending from left to right margin).

2. In 10 point bold type, show "Details about this notice. (See the back for more information.)" Print this text in 10% shading.

3. Horizontal line (0.008" wide extending from left to right margin).

4. Display the provider name(s) and address(es), control number(s) (break control numbers into segments (see sample)), headings, and service detail according to the rules described below. The length and appearance of the service display will vary according to whether the *MSN* is for an assigned or unassigned claim. Print all of this information in 10 point type and bold where indicated.

For assigned claims (one billing provider, possibility of multiple control numbers), print, under the horizontal line, the following information in this order:

- "BILL SUBMITTED BY:", in all uppercase letters in 10 point bold type;

- On the same line starting one half inch beyond the end of "BILL SUBMITTED BY:", print the name of the provider. When using "M.D." with the provider name, place a period after the "M" and after the "D."

- Directly underneath the words "BILL SUBMITTED BY:" print the words "Mailing address:" Print the address directly underneath the name of the provider and on a single line, if possible.

- If the service was provided at a clinic/group practice that bills for its physicians, show the clinic/group practice name; and

- If a solo practicing physician performed the service(s), show his/her name and complete mailing address.

For clinic/group practice billing, show the performing physician's name as follows:

- Blank line;

- Print the following headings in 10 point bold:

  - Dates;

- Services and Service Codes;
- Charge;
- Medicare Approved; and
- See Notes Below.

Print the "Dates" heading aligned with the left margin. Print the "Services and Service Codes" heading aligned with the provider name and mailing address. Use appropriate spacing as shown in Exhibits 1, 2, and 3 to print the remaining headings on the same line.

The information printed under each heading is described later in this section.

- Control number in 10 point bold type;
- Performing physician's full name in 10 point bold type;
- Service items for performing physician;
- Blank line;
- If there is only one control number and one provider: after all of the service items have been listed, sum the charged and approved amounts to derive a total. Print a "+" beside the "charge" and "approved" amounts of the last line item and underline. Print "Total" in 10 point bold type face aligned with the left edge of the summary box found in area I and print the totals for the "Charge" and "Medicare Approved" columns. A "$" is printed before each dollar total.

Use the totals of the "Charge" and "Medicare Approved" columns in the summary block in Area I. Also, use the total "Medicare Approved" amount in Area IV.

Suppress "Total" if only one line item appears on the *MSN*. There is no need to total one line item.

NOTE: For multiple control numbers and providers, do not follow the directions in number 8. until all control numbers, providers, and service items have been listed. For multiple performing physicians under the same control number, repeat numbers 5., 6., and 7. until all performing physicians' names and service items have been listed. For multiple control numbers, repeat numbers 4., 5., 6., and 7. until the performing physicians names and service items for all control numbers have been printed. After the last provider's services have been listed for the last control number, sum the charged and approved amounts. Do not leave a blank line between the last service item and the "Total."

For unassigned claims (one control number, possibility of multiple providers), print, under the horizontal line, the following information in this order:

- Control number in 10 point bold type;
- Blank line;
- "BILL SUBMITTED BY:", in all uppercase letters in 10 point bold type;
- On the same line, one half inch beyond the end of "BILL SUBMITTED BY:", print the name of the physician/supplier providing the medical service or supplies. Directly beneath the words "BILL SUBMITTED BY:" print the heading: "Mailing address:". Print the mailing address directly underneath the name of the physician/supplier. Print this information in no more than two lines.
- If the service was provided at a clinic/group practice that bills for its physicians, show the clinic/group practice name; and
- If a solo practicing physician performed the services, show his/her name and complete mailing address.

For clinic/group practice billing, show the performing physician's name immediately before the services he/she performed in 10 point bold type as directed below. If the system does not carry the clinic/group name for unassigned claims, show the performing provider's name in place of the clinic/group name followed by the clinic/group address.

- Blank line.
- Print the following headings in 10 point bold underlined:
    - Services and Service Codes,
    - Dates,
    - Charge,
    - Medicare Approved, and
    - See Notes Below.

Print the "Dates" heading aligned with the left margin. Print the "Services and Service Codes" heading aligned with the provider/supplier name and address. Use appropriate spacing as shown in Exhibits 1, 2 and 3 to print the remaining headings on the same line.

The information printed under each heading is described later in this section.

- Print the performing physician's name in 10 point bold type if the provider is a clinic. List all service items in chronological order for that physician. For each performing physician billed by a clinic, list his/her name in 10 point bold type followed on the next line by the service item(s). Generally there is only one provider. If so, after all of the service items have been listed, sum the charged and approved amounts to derive a total. Print a "+" beside the "charge" and "approved" amounts of the last line item and underline. Print "Total" in 10 point bold type face aligned with the left edge of the area I summary box and print the totals for the "Charge" and "Medicare Approved" columns. Print a "$" before each dollar total.
Use the totals of the "Charge" and "Medicare Approved" columns in the summary block in Area I. Also, use the total "Medicare Approved" amount in Area IV.

Suppress "Total" if only one line item appears on the MSN. There is no need to total one line item.

NOTE 1: For multiple providers (when beneficiaries submit claims, see Note 2), do not print the totals until all providers and service items have been listed. For each provider, print the information shown above for unassigned claims. After the last provider's services have been listed, sum the charge and approved amounts. Do not leave a blank line between the last service item and "Total".

NOTE 2: Unassigned claims are submitted by providers and should, therefore, be one claim to one *MSN*. However, produce an *MSN* showing multiple providers when beneficiaries have submitted claims. Generate these when:

  - Services were provided before September 1, 1990;

  - Services were not covered by Medicare and beneficiaries want a formal coverage determination;

  - Physicians or suppliers refuse to submit claims for services on or after September 1, 1990;

  - Services were provided outside the United States;

  - Used DME is purchased from a private source; or

  - Medicare is secondary payer.

- Aligned with the left margin, print the following statement in 10 point bold type: "Your provider(s) did not accept assignment. We are paying you the amount that we owe you. See #4 on the back." (NOTE: print this statement on a single line preceded by a blank line). Do not print the "We are paying you the amount that we owe you" portion of the message when no payment is made.

The data printed under each of the headings mentioned above are described here. Print each service, code, date, charge, approved amount and notes on one line.

The "Services Provided" column contains the number of services, HCPCS code short descriptor, procedure code, and modifiers. Print in mixed case equivalent to 10-point type. The first 3 bytes are fixed and reserved for the number of services. Right justify the number of services within these 3 bytes. Byte 4 is a space. Bytes 5 through 47 are reserved for the HCPCS short descriptors, procedure codes and modifiers. Print each service description in no more than 1 line in mixed case equivalent to 10-point type. Follow the descriptor by procedure code, and modifier(s) if necessary, in parentheses. The carrier separates procedure codes and modifiers with a dash.

Print the following modifier descriptors on the next line when applicable. When printing a modifier descriptor, drop the procedure code and its modifier(s) to the line with the modifier descriptor. Begin printing the procedure code directly under the short descriptor. The modifier descriptor should follow immediately after the procedure code.

Services and applicable modification codes and descriptions are shown in the following table.

Service	**Modifier Code**	**Modifier Description on MSN(s)**
Assistant surgery	80, 81, and 82	Assistant surgeon
Professional component	26	Professional charge
Technical component	TC	Technical charge
DME rental	RR	Rental
DME purchase	NR	Purchase
DME maintenance/service	MS	Maintenance/service
DME replacement/repair	RP	Replacement/repair
Post-op care	55	Care after operation
Pre-op care	56	Care before operation
Ambulatory surgical center fees	SG	Surgery center fee

NOTE FOR *DME MACs*: If there are three or more modifiers, drop the procedure code and its modifiers to the next line. Begin printing the procedure directly under the short descriptor. The modifier descriptor should follow immediately after the procedure code.

Dates - Use the first three letters of the month name as a three letter abbreviation for the month. If the services extended over several days or into the following month, use a "-" to show the extension.

Charges - Show submitted charge(s). Print the dollar sign on the first line. After of the service items have been listed, sum the charges to derive a total. Print a "+" beside the charge for the last line item and underline.

Medicare Approved - Show the fee schedule amount or approved charge. For claims involving psychiatric outpatient services, print the approved amount before the psychiatric reduction. Print the dollar sign on the first line. After all of the service items are printed, sum the charges to derive a total. Print a "+" beside the charge for the last line item and underline.

See Notes Below - Print the heading if there are any explanatory notes. Suppress the heading if the MSN does not require notes.

Enter "a" for the first line item which requires explanation. See §30.2 for a list of the notes to be used on the MSN. Place "a" and the appropriate explanation from §30.2 under "Notes." If another line item is reduced or disallowed for the same reason, also print "a" beside this line item. If the system provides a second explanation for this line item, print the letter "b", preceded by a comma. Enter the explanation from §30.2 in the "Notes" section. Show no more than 5 alphabetic codes and notes per line.

Print notes pertaining to a single line by entering the alphabetic code in the "Notes" column to the right of the line. When there is more than one claim on the MSN, print notes pertaining to a single claim to the right of the claim control number. Print notes pertaining to all claims to the right of the "Total" amount.

- Horizontal line (0.018" wide extending from left to right margin). If Area III starts on a subsequent page, do not print this horizontal line.

Align all dollar amounts appearing in Area II by decimal. For zero dollar amounts, show "0.00".

Additional Claims Information Specifications

- The contractor may split a claim between pages if the claim is more than 10 lines long. If there is insufficient space to print at least 5 lines, do not split the claim. Put the claim on the next page.

- If there is a need to continue the “Claims Information Box” past the first page, print the program status line on the top of continuing pages in the upper left corner below the header, followed by “(continued)” equivalent to 12-point bold lower case type.

- Repeat column headings and line specifications according to the preceding instructions.

- Allow 1 equivalent to 12-point blank line between claims information and beginning of notes section.

- (CARRIERS ONLY): If no “Notes” section is printed, the blank line should precede the section that follows. When a single MSN contains both assigned and unassigned claims, each claim type should be displayed in its appropriate box. The boxes should follow directly after each other. Allow one 12-point blank line between the bottom line of the first box and the assignment status line of the second box. Each box should be created following the specifications in this section. When assigning alphabetic codes for the “See Notes Section” column, if the same message is needed in both the assigned and unassigned claims information boxes, print the same alphabetic code each time the message is required. When a claim in the second claims information box requires a new message, use the next available alphabetic code after the last code used in the preceding box.

- The MSN may be split if more than 99 claims are processed in one 30-day period or if more than 99 no-pay claims are processed in one 90 day period.

- Do not print claims denied as duplicates.

10.3.7 - Message Section

(Rev.1491, Issued: 04-11-08, Effective: 05-12-08, Implementation: 05-12-08)

A. General Information about “Message” Section

The “Message” section consists of three parts.

- The “Notes” section contains alphabetic codes and messages explaining the claim and service line determinations;

- "Deductible Information” contains messages communicating deductible status for each year of service or benefit period displayed on the MSN; and

- "General Information” contains news of general interest that is issued to all beneficiaries.

B. Technical Specifications for “Message” Section

The following outlines the technical specifications for each element of the “Message” section.

"Notes” Section

- Print a box equivalent to 1-point line around the “Notes” section.

- The length of the “Notes” section varies depending on the number of messages needed. If there are no messages to be printed, suppress the entire “Notes” section.

- Allow a 1-byte margin between the “Notes” section box line and the beginning and ending of printed information.

- Print “Notes Section:” title equivalent to 14-point bold mixed case type. Indent 1 byte and print “Notes Section.”

- Allow equivalent to 12-point blank line.

- Indent the alphabetic code(s) 2 bytes from the margin.

- List the message codes in alphabetic order.

- Print the alphabetic codes equivalent to 12-point lower case type. Print the messages equivalent to 12-point bold mixed case type. Print additional alphabetic codes in upper case equivalent to 12-point type. Print all the messages in mixed case equivalent to 12-point type.

- Allow 2 bytes between the alpha code and the message.

- Indent additional lines of each message 5 bytes from the margin.

- Allow equivalent to 12-point blank line between messages.

- Do not print the “Notes Section” title without at least 1 complete message following it on the same page.

- Do not split messages. Each message must be printed in its entirety on the same page.

- Print “(continued)” equivalent to 12-point bold type in the bottom right corner of the “Notes Section” box when the “Notes Section” box continues onto another page.

- Print the title “Notes Section (continued):” equivalent to 14-point bold mixed case type in the upper left corner of the next page below the header.

- All “Notes Section” boxes should be closed on each page that they appear.

- Intermediaries allow 2 equivalents to 12-point blank lines between “Notes Section” box and “Deductible Information.” Carriers allow one 12-point blank line between the “Notes Section” box and the “Deductible Information” section.

"Deductible Information” Section

- Print “Deductible Information:” title equivalent to 14-point bold mixed case type.

- Allow equivalent to 12-point blank line.

- Indent 3 bytes and print deductible messages equivalent to 12-point mixed case type.

- Suppress the “Deductible Information” section if there is no record of entitlement for the beneficiary, or denial.

- Suppress the Deductible Information section if all claims displayed on the MSN are denied for HMO involvement or transferred to another agency or carrier (e.g., Travelers, UMWA, carrier jurisdiction.)

- Print the appropriate deductible message(s) *from the MSN message file at the hyperlink in §50, message section 37 “Deductible/Coinsurance”.*

- Multiple deductible messages should appear for outpatient MSN’s if multiple calendar years of service are displayed on the MSN and for inpatient MSN’s if multiple benefit periods appear. Print messages in chronological order by year. Allow one 12-point blank line between messages.

- Do not split the “Deductible Information” section. There will, in most cases, be only 1 message printed here. If the contractor cannot print the title and all deductible messages on 1 page, print all information on the next page.

- If there is more than 1 message, allow equivalent to 12-point blank line between each.

- Allow 2 equivalents to 12-point blank lines between the last line of the “Deductible Information” section and the “General Information” title.

- Suppress the “Deductible Information” section if all claims displayed on the MSN are denied for HMO involvement or transferred to another agency or carrier (e.g., Travelers, UMWA, carrier jurisdiction).

"General Information” Section

- Print “General Information” title equivalent to 14-point bold mixed case type.

- Allow equivalent to 12-point blank line.

- Indent 3 bytes from the margin and print “General Information” messages equivalent to 12-point mixed case type.

- Suppress the “General Information” section if there are no messages to print.

- Do not print the “General Information” title without at least 1 complete message following it on the same page.

- Do not split messages. Each message must be printed in its entirety on the same page.

- Allow equivalent to 12-point blank line between messages.

- Print the title “General Information (continued):” equivalent to 14-point bold mixed case type in the upper left corner of the next page below the header when information continues to another page.

- Messages for “General Information” should be clear, concise and relevant. Submit proposed messages to the regional office (RO) for approval. The RO will notify the CO of the need for the message and seek approval. The RO will determine the appropriate length of time to display each message.

- Allow 2 equivalents to 12-point blank lines between the last line of “General Information” and the “Appeals Information” title.

- If multiple messages are printed in this section, allow one 12-point blank line between messages. If no “General Information” messages are printed on the MSN, suppress the “General Information” section.

10.3.8 - Appeals Section

(Rev.1491, Issued: 04-11-08, Effective: 05-12-08, Implementation: 05-12-08)

A. General Information About the Appeals Section

This section informs the beneficiary of his/her appeal rights. Print only Part B medical insurance language if only Part B information is on the MSN. Print only Part A information if only Part A information is on the MSN. Print both Part A and B appeals language side by side if both claim types are on the MSN.

B. Technical Specification

The following outlines the technical specifications for the Appeals section.

- The "Appeals Section" must be printed in its entirety. Display it at the bottom of the last page of the MSN if space permits. Otherwise, print it in its entirety at the top of the next page (which then becomes the last page).

- Print "Appeals Information - Part B" or "Part A," whichever is applicable, equivalent to 14-point bold mixed case type flush left. The word "(Outpatient)" or "(Inpatient)" should follow Part B or Part A.

- Allow equivalent to 12-point blank line.

- Fiscal intermediaries only, print, "If you disagree with any claims decision on either Part A or Part B of this notice, your appeal must be received by (appeal date). Follow the directions below:" in equivalent to 12-point mixed case type, flush left.

    - "If you disagree with any claims decision on either Part A or Part B of this notice," and the appeal date should be bold.

    - The appeal date is 125 days from the notice date on page 1 for Part B and 125 days from the notice date on page 1 for Part A. Date format is month, day, year (e.g., October 1, 1997).

- Carriers only, print, "If you disagree with any claims decision on this notice, your appeal must be received by (appeal date). Follow the directions below:" in equivalent to 12-point mixed case type, flush left.

    - "If you disagree with any claims decision on this notice," and the appeal date should be bold.

    - The appeal date is 125 days from the notice date on page 1 for Part B and 125 days from the notice date on page 1 for Part A. Date format is month, day, year (e.g., October 1, 1997).

NOTE: Section 1869(a)(3)(C) of the Act eliminates the distinction between the time limits for requesting a Part A reconsideration and Part B review by creating a 120-day time limit for filing requests for appeal of all initial determinations. This time limit is calculated based upon 120 calendar days from the date the beneficiary receives the MSN. For the purposes of calculating the receipt of the MSN, it is presumed that the beneficiary received the MSN 5 days after the date on the MSN, unless there is evidence to the contrary. Therefore, the cut off for the appeal date noted on the MSN shall be calculated based on 125 days from the notice date on page 1 of the MSN.

- Allow equivalent to 12-point blank line.

- Format each of the following 3 lines by indenting 11 bytes:

- Intermediaries number 1 through 3 each and skip 3 additional bytes;

- Carriers print the number followed by the closed parenthesis and skip 2 additional bytes;

- Allow equivalent to 12-point blank line between each printed line. Print all information equivalent to 12-point mixed case type. This information should only be shown once and centered if both Part A and B appeals language is shown. (See exhibit 1 in §30.)

"1. Circle the item(s) you disagree with and explain why you disagree.

"2. Send this notice, or a copy, to the address in the "Customer Service Information" box on page 1. (You may also send any additional information you may have about your appeal.)

"3. Sign here _____ Phone number (____) _____."

The DME MACs shall change the Appeals Information section of the MSN to read as follows:

If you disagree with any claims decisions on this notice, your appeal must be received by (appeal date). Follow the instructions below:

1) Circle the item(s) you disagree with and explain why you disagree.

2) Send this notice, or a copy, to the following address:(**INSERT YOUR DME MAC ADDRESS)(**You may also send any additional information you may have about your appeal.)

3) Sign here_____ Phone number (__)_____

The DME MACS shall make these changes for both English and Spanish MSNs.

The DME MAC appeals address should start on the same line immediately following the colon after the phrase "Send this notice, or a copy, to the following address:"

The DME MAC and all future MACs shall change the Appeals Information section of the MSN to read as follows:

If you disagree with any claims decisions on this notice, your appeal must be received by (appeal date). Follow the instructions below:

1) Circle the item(s) you disagree with and explain why you disagree.

2) Send this notice, or a copy, to the following address: (**INSERT YOUR MAC ADDRESS)** (You may also send any additional information you may have about your appeal.)

3) Sign here_____ Phone number (__)_____

The *DME* MAC and all future MACs shall make these changes for both English and Spanish MSNs.

The *DME* MAC appeals address should start on the same line immediately following the colon after the phrase "Send this notice, or a copy, to the following address:"

The FIs and carriers who opted to use an "interim solution" for written correspondence during the transition to the BCC, and before being fully transitioned to a MAC, shall follow the modified interim process described below. This only applies to those contractors who have not transitioned to a MAC or DME MACs, and their current MSN Appeals section language directs the beneficiary to refer to the Customer Service Information Box for an appeals address. All other contractors, A/B MACs, and DME MACs should follow the already existing appeals instructions above.

Interim Process:

Contractors shall add the following message in the General Information section of the

MSN:

NOTICE: Please send written appeal requests to (insert contractor appeals address). Only appeals related correspondence sent to this address will be answered. For general inquiries, please call 1-800 MEDICARE.

AVISO: Por favor envíe las apelaciones por escrito a (introduzca la dirección del contratista responsable por la apelación). Sólo contestaremos correspondencia relacionada con apelaciones enviada a esta dirección. Para información general, por favor llame GRATIS al 1-800-MEDICARE.

10.3.10.1 - Intermediary Calculations

(Rev.1491, Issued: 04-11-08, Effective: 05-12-08, Implementation: 05-12-08)

A. "You May Be Billed" Column

The following chart is to be used to display the "You May Be Billed" amounts for each service line on outpatient claims other than those that have a Medicare secondary payment less than the amount Medicare would have paid if it were primary. See the Medicare Secondary Payer Manual, Chapter 5, if the Medicare secondary payment is less than the amount Medicare would pay if it were primary.

Calculations for Completing "You May Be Billed" Column - Outpatient Claims	**Instructions/Source of Dollar Amount for Calculations**
A. Service line billed amount	This is the service line billed amount. This amount should be shown in the "Amount Charged" column of the MSN.
B. Psychiatric reduction	B = A x .375 This is applicable only to services subject to the outpatient psychiatric limitation. For all other services, B = 0.
C. Amount remaining after psychiatric reduction	C = A - B.
D. Deductible applied	This is the amount of deductible applied on the service line. If no deductible applied, D = 0.
E. Amount charged less deductible	E = C - D.
F. Less Medicare copayment amount	Depending upon the service, F may equal any of: 1. E - where services are paid at 100% of the approved amount; 2. 80% of E - where coinsurance is based on approved amount; 3. E minus 20% of E - where coinsurance is based on charges; or 4. OPPs payment amount minus the fixed beneficiary copayment where hospital outpatient PPS is involved.
G. Amount after deductible, copayment and psychiatric reduction	G = E - F.
H. Of the billed amount	This is dollar amount shown in "A."
I. Less what Medicare owes	This is the dollar amount shown in "G."
J. Net responsibility	J = H - I.
K. Plus charges that Medicare does not cover	This step represents charges that Medicare does not cover shown in the "Noncovered Charges" column on

Calculations for Completing "You May Be Billed" Column - Outpatient Claims	Instructions/Source of Dollar Amount for Calculations
	the MSN. Charges for which the beneficiary is determined to have no liability should be excluded from this step. Exclude dollar amounts for denials such as: • Services determined not to be medically necessary and the beneficiary was not informed in writing, in advance, that the services may not be paid; • The provider failed to tell the beneficiary if the diagnostic test was purchased, from whom it was purchased, the acquisition cost of the purchased test, or the cost of the professional component; • Missing information such as ICD-9, UPIN, etc.; • The charge was denied as a duplicate; • The service was part of a major surgery, test panel or bundled code; or • The service was denied/reduced because of utilization reasons.
L. Beneficiary responsibility	L = J + K Display this amount in the "You May Be Billed" column for service lines on outpatient claims. Claims submitted with a beneficiary paid amount require the additional calculations shown in Subsection C below.

B. Display of the "You May Be Billed" Column for MSP Claims:

If the Medicare secondary payment plus the amount the primary insured paid equals or exceeds what Medicare would have paid, the "You May Be Billed" column for each approved service should display "$0.00."

If the primary insurer paid amount is less than what Medicare would have paid, the amount shown in "You May Be Billed" column for each service line needs to be reduced using the following formula.

For the first service line, the amount "You May Be Billed" = Deductible + Coinsurance - Primary Paid Amount + Noncovered Charges.

For the second service line, the same formula would be followed with the Primary Amount equaling the Primary Paid minus the Deductible + Coinsurance from the first line.

Continue in this manner until the primary paid amount equals either $0.00 or the Deductible + Coinsurance equals $0.00.

EXAMPLE 1:

On this claim, the Medicare payment would have been $2,172.54. The primary insurer paid $2,400.00, and $543.14 would have been applied to coinsurance.

Services Provided	**Amount Charged**	**Non-Covered Charges**	**Deductible and Coinsurance**	**You May Be Billed**	**See Notes Section**
Sick Hospital 123 West Street Little Rock, AR 72204 Referred by: John Smith, M.D.					
01/01/95 - 01/31/95 Dialysis	$2,715.68	$00.00	$543.03	$00.00	A

Notes Section:

a. Your primary group's payment satisfied Medicare deductible and coinsurance.

EXAMPLE 2:

On this claim, the Medicare payment would have been $230.56. These services have no coinsurance applied, and $100 was applied to deductible. The primary insurer paid $800.00.

Services Provided	Amount Charged	Non-Covered Charges	Deductible and Coinsurance	You May Be Billed	See Notes Section
Sick Hospital 456 Sick Lane Wellness, TX 75256 Referred by: John Apple, M.D.					
Clinical Chemistry Test	$300.00	$00.00	$00.00	$00.00	
Radiologic Exam	600.00	00.00	100.00	00.00.	
Claim Total	$900.00	$00.00	$100.00	$00.00	

Notes Section:

a. Your primary group's payment satisfied Medicare deductible and coinsurance.

EXAMPLE 3:

On this claim, the Medicare payment would have been $380.35. The primary insurer paid $350.00, $100 was applied to deductible and $205.00 to coinsurance. (Since it is not clear from the paid amount whether the take home drugs were paid, the MSN must show as "You May Be Billed.")

Services Provided	Amount Charged	Non-Covered Charges	Deductible and Coinsurance	You May Be Billed	See Notes Section
Well Hospital **123 Well Lane** **Secondary, Texas 75123** Referred by: John Sick, M.D.					
Pharmacy	$80.00	$00.00	$80.00	$00.00	
Take Home Drugs	20.00	20.00	00.00	20.00	a
Prosthetics/Orthotic (L3800)	150.00	00.00	46.00	00.00	
Medical/Surgical Supplies	50.00	00.00	10.00	00.00	
Culture (87117)	30.00	00.00	00.00	00.00	b
X-Ray (71020)	45.00	00.00	9.00	00.00	
Bronchoscopy (31622)	500.00	00.00	100.00	00.00	
Anesthesia	200.00	00.00	40.00	00.00	
Immunization (90732)	20.00	00.00	00.00	00.00	b
EKG (93005)	100.00	00.00	20.00	00.00	
Vaccine Administration (G0009)	15.00	00.00	00.00	00.00	b
Claim Total	$1,210.00	$20.00	$305.00	$20.00	c

Notes Section:

a. Medicare does not pay for this item or service.

b. This service is paid at 100% of Medicare approved amount.

c. Your primary group's payment satisfied Medicare deductible and coinsurance.

C. Display of the "You May Be Billed" Column for Claims Submitted with a Beneficiary Paid Amount

If a claim is submitted with a beneficiary paid amount, the amount(s) in the "You May Be Billed" column will be reduced by the amount the beneficiary prepaid the provider.

Apply the beneficiary paid amount to each service line sequentially until the beneficiary paid amount is reduced to zero or all service lines have been considered.

Step 1: If the amount the beneficiary paid is less than or equal to the amount shown for the "You May Be Billed" column, subtract the amount the beneficiary paid from that amount, and display the difference in the "You May Be Billed" column for that service line.

Step 2: If the amount the beneficiary paid is greater than the amount calculated for the "You May Be Billed" column, subtract the "You May Be Billed" amount for the first service line from the amount the beneficiary paid, and show zero in the "You May Be Billed" column.

Repeat these steps with any remaining beneficiary paid amounts. If a balance remains after all services lines have been considered, that amount should match the check amount to the beneficiary on that claim. If payment was made to the beneficiary, the balance should be shown in the appropriate blank of message *34.4 (use the hyperlink in §50 to the MSN message file, go to message section 34.)* If a check was not issued, print message 34.2.

EXAMPLE 4:

On this claim, the beneficiary paid $75.00.

Services Provided	Amount Charged	Non-Covered Charges	Deductible and Coinsurance	You May Be Billed	See Notes Section

Sick Hospital **123 West St.** **Jacksonville, FL 32231** Referred by: John Smith, M.D.					
Dialysis	$367.68	$00.00	$73.53	$00.00	A

Notes: a. We are paying you $1.47 because the amount you paid the provider was more than you may be billed.

10.3.10.2 - Carrier Calculations

(Rev.1491, Issued: 04-11-08, Effective: 05-12-08, Implementation: 05-12-08)

A. "Medicare Paid You/Provider" Column - Assigned and Unassigned Claims

The following chart is to be used to display the Medicare paid amount for each service line on assigned and unassigned claims other than those that have a Medicare secondary payment less than the amount Medicare would have paid if it were primary.

Steps for Displaying "Medicare Paid Amounts" on the Service Line	**Instructions/Source of Dollar Amounts**
A. Service line approved amount	This is the approved amount for the service. Do not include interest amounts paid or applied to the service line.
B. Mental Health Treatment Limitation	B = A x 37.5 This is applicable only for services subject to the outpatient mental health treatment limitation. For all other services, B = 0.
C. Amount remaining after mental health treatment limitation	C = A - B.
D. Deductible applied	This is the amount of deductible applied on the service line. If no deductible applied, D = 0.
E. Approved amount less deductible	E = C - D.

Steps for Displaying "Medicare Paid Amounts" on the Service Line	Instructions/Source of Dollar Amounts
F. Less Medicare copayment	F = E x .20 Services paid at 100% of the approved amount do not have a copayment. For services paid at 100%, F = 0.
G. Amount after deductible, copayment and mental health treatment limitation	G = E - F.
H. Less 10% for late filing	H = G x .10 If service line is part of an unassigned claim or there is no reduction for late filing, H = 0.
I. Payment after reduction	I = G - H.
J. Less Balanced Budget Law Reduction	The total Balanced Budget Law reductions applied to the service line. If no reduction, J = 0.
K. Payment after reduction	K = I - J.
L. Medicare paid amount	L = K - Display this amount in the "Medicare Paid You/Provider" column.

B. "You May Be Billed" Column - Assigned Claims

The following chart is to be used to display the "You May Be Billed" amounts for each service line on assigned claims other than those that have a Medicare secondary payment less than the amount Medicare would have paid if it were primary.

Calculations for Completing "You May Be Billed" Column - Assigned Claims	Instructions/Source of Dollar Amount for Calculations
A. Service line approved amount	This is the service line approved amount. This amount should be shown in the "Medicare Approved" column of the MSN.
B. Mental Health Treatment Limitation	B = A x 37.5 This is applicable only to services subject to the outpatient psychiatric limitation. For all other services, B = 0.
C. Amount remaining after mental	C = A - B.

Calculations for Completing "You May Be Billed" Column - Assigned Claims	**Instructions/Source of Dollar Amount for Calculations**
health treatment limitation	
D. Deductible applied	This is the amount of deductible applied on the service line. If no deductible applied, D = 0.
E. Approved amount less deductible	E = C - D.
F. Less Medicare copayment amount	F = E x .20 Services paid at 100% of the approved amount do not have a copayment. For services paid at 100%, F = 0.
G. Amount after deductible, copayment and mental health treatment limitation	G = E - F.
H. Of the approved amount	This is dollar amount shown in "A."
I. Less what Medicare owes	This is the dollar amount shown in "G."
J. Net responsibility	J = H - I.

Calculations for Completing "You May Be Billed" Column - Assigned Claims	Instructions/Source of Dollar Amount for Calculations
K. Plus charges that Medicare does not cover	This step represents charges that Medicare does not cover and the beneficiary is liable. Charges for which the beneficiary is determined to have no liability should be excluded from this step. Exclude dollar amounts for denials or reductions such as: • Services determined not to be medically necessary and the beneficiary was not informed in writing, in advance, that the services may not be paid; • The provider failed to tell the beneficiary if the diagnostic test was purchased, from whom it was purchased, the acquisition cost of the purchased test, or the cost of the professional component; • Missing information such as ICD-9, UPIN, etc.; • The charge was denied as a duplicate; • The service was part of a major surgery, test panel or bundled code; or • The service was denied/reduced because of utilization reasons.
L. Beneficiary responsibility	L = J + K Display this amount in the "You May Be Billed" column for service lines on assigned claims. Claims submitted with a beneficiary paid amount require additional calculations. See Subsection F below.

C. "You May Be Billed" Column - Unassigned Claims

The following chart is used to display the "You May Be Billed" amounts for each service line on unassigned claims other than those that have a Medicare secondary payment less than the amount Medicare would have paid if it were primary.

Calculations for Completing "You May Be Billed" Column -	Instructions/Source of Dollar Amount for Calculations

Unassigned Claims	
A. Of the total charges	The billed amount for the service line.
B. Approved amount	The service line approved amount.
C. Amount exceeding limiting charge	For unassigned services subject to the limiting charge, this is the actual dollar amount by which the limiting charge is exceeded. If the amount is less than $1.00, C = 0. Do not include services being reduced or denied for any of the conditions under E.
D. Net Responsibility	D = A - C.
E. Less charges beneficiary is not liable for	This step represents charges that were denied or reduced and the beneficiary is not liable for the denial or the reduction. Include dollar amounts for denials or reductions such as: • Services determined not to be medically necessary, and the beneficiary was not informed in writing in advance that the services may not be paid; • The provider failed to tell the beneficiary if the diagnostic test was purchased, from whom it was purchased, the acquisition cost of the purchased test, or the cost of the professional component; • The claim did not have an ICD-9 code listed, or the service was not linked to an ICD-9 code; • The charge was denied as a duplicate; • The service was part of a major surgery, test panel, or bundled code; • The service was denied because of utilization reasons; or • Rebundling of services when the minor service was paid before the major service was billed. Use the amount allowed for the minor service in step E, or Reductions due to coverage.

F. Beneficiary Responsibility	F = D - E Display this amount in the "You May Be Billed" column for unassigned claims. Claims submitted with a beneficiary paid require additional calculations, therefore, proceed to §10.3.10.2(f).

D. Display of the "Medicare Paid You" and "Medicare Paid Provider" Columns for MSP Claims

Medicare secondary payment is computed by the MSP pay module based on claim totals.

However, the MSN displays calculations by service line. In order to complete the "Medicare Paid Provider" and "Medicare Paid You" columns for MSP claims, the contractor must apportion the total amount Medicare paid on the claim among the approved service lines.

For the first approved service line, show the lesser of 80 percent (50 percent if the outpatient psychiatric limit applies, or 100 percent for services paid at 100 percent) of the Medicare approved amount, less any deductible applied, or the amount Medicare actually paid on the claim.
For the second approved service line, show the lesser of:

- 80 percent (50 percent if the outpatient psychiatric limit applies, or 100 percent for services paid at 100 percent) of the Medicare approved amount less any deductible applied, or

- The actual amount Medicare paid on the claim minus the amount shown under Medicare Paid for the prior approved service lines.

Continue on following lines in this manner until the entire Medicare secondary payment for the claim has been exhausted.

EXAMPLE:

Dates of Service	Services Provided	Amount Charged	Medicare Approved	Medicare Paid Provider	You May Be Billed	See Notes Section
John Smith, M.D. 123 West Street Jacksonville, FL 32231						
06/06/95	1 Office/Outpatient Visit, Est. (99214)	$80.00	$57.25	$45.80	$0.00	b
06/06/95	1 Removal of Skin Lesion (11441)	$65.00	$49.71	$14.20	$0.00	b, c
06/06/95	1 Destroy Benign/Premal. Lesion (17000)	$40.00	$16.52	$0.00	$0.00	b, c
Claim Total		$185.60	$123.48	$60.00	$0.00	a

Notes Section:

a. Medicare's secondary payment is $60.00. This is the difference between the primary insurer's approved amount of $150.00 and the primary insurer's paid amount of $90.00.

b. The amount listed in the "You May Be Billed" column assumes that your primary insurer paid the provider. If your primary insurer paid you, then you are responsible to pay the provider the amount your primary insurer paid to you plus the amount in the "You May Be Billed" column.

c. Medicare benefits are reduced because some of these expenses have been paid by your primary insurer.

E. Display of the "You May Be Billed" Column for MSP Claims

1. Assigned Claims

If the Medicare secondary payment plus the amount the primary insurer paid equals or exceeds the Medicare approved amount, display "$0.00" in the "You May Be Billed" column for each approved service line.

If the Medicare secondary payment plus the amount the primary insurer paid is less than the Medicare approved amount, carriers calculate the total beneficiary responsibility for

approved services by subtracting the sum of the primary insurer's payment and the Medicare secondary payment from the total Medicare approved amount for those services.

> Amount Medicare Approved on Claim - (Primary Insurer Payment + Medicare Payment) = Total Beneficiary Responsibility

For the first approved service line, carriers show the lesser of 20 percent (50 percent if the outpatient psychiatric limit applies) of the Medicare approved amount or the beneficiary's total responsibility for all approved services on the claim.

For the second approved service line, carriers show the lesser of 20 percent (50 percent if the outpatient psychiatric limit applies) of the approved amount for the line or the beneficiary's total responsibility for approved services minus the amount shown for the prior approved service line.

Continue in this manner until the entire beneficiary responsibility has been exhausted.

Enter $0.00 in the "You May Be Billed" column for denied services for which the beneficiary is not liable.

Enter the amount charged in the "You May Be Billed" column for denied services for which the beneficiary is responsible.

NOTE: If there is an "obligated to accept" amount submitted on the claim, and that amount is greater than zero but less than the Medicare approved amount, use the "obligated to accept" amount in place of the Medicare approved amount when performing the above calculations.

EXAMPLE: On this claim, the regular Medicare payment was the lowest of the calculated secondary payments. $38.31 was applied to the annual deductible. The primary insurer allowed $134.19 and paid $52.38.

Dates of Service	Services Provided	Amount Charged	Medicare Approved	Medicare Paid Provider	You May Be Billed	See Notes Section
John Smith, M.D. 123 West Street Jacksonville, FL 32231						
06/06/95	1 Evaluation of Wheezing (94060)	$55.82	$55.82	$14.01	$5.10	b, c
06/06/95	1 Respiratory Flow Volume (94375)	$36.43	$36.43	$29.14	$0.00	c
06/06/95	1 Lung Function Test (94200)	$17.42	$17.42	$13.94	$0.00	c
06/06/95	1 Measure Blood Oxygen (94761)	$24.52	$24.52	$19.62	$0.00	c
Claim Total		$134.19	$134.19	$76.71	$5.10	a

Notes Section:

a. Your provider is allowed to collect a total of $134.19 on this claim. Your primary insurer paid $52.38 and Medicare paid $76.71. You are responsible for the unpaid portion of $5.10.

b. $38.31 of this approved amount has been applied to your deductible.

c. The amount listed in the "You May Be Billed" column assumes that your primary insurer paid the provider. If your primary insurer paid you, then you are responsible to pay the provider the amount your primary insurer paid to you plus the amount in the "You May Be Billed" column.

2. Unassigned Claims

The amount in the "You May Be Billed" column for approved services is the amount charged or the limiting charge, whichever is less.

NOTE: If there is an "obligated to accept" amount submitted on the claim and that amount is greater than zero but less than the amount charged or the limiting charge, use the "obligated to accept" amount when performing this calculation.

Enter $0.00 in the "You May Be Billed" column for denied services for which the beneficiary is not liable. Enter the amount charged in the "You May Be Billed" column for denied services for which the beneficiary is responsible.

F. Display of the "You May Be Billed" Column for Claims Submitted with a Beneficiary Paid Amount

1. Assigned Claims

If an assigned claim is submitted with a beneficiary paid amount, the amount(s) in the "You May Be Billed" column will be reduced by the amount the beneficiary prepaid the provider.

Apply the beneficiary paid amount as indicated below to each service line sequentially until the beneficiary paid amount is reduced to zero or all service lines have been considered.

Step 1: Subtract the amount of the beneficiary check, if any, from the patient amount submitted on the claim. Use the difference as the new patient paid amount. If there was no check to the beneficiary, use the patient paid amount submitted on the claim for remaining steps.

Step 2: If the new patient paid amount is less than or equal to the amount calculated for the "You May Be Billed" column, subtract the new patient paid amount from the original "You May Be Billed" amount, and display the difference in the "You May Be Billed" column for that service line.

Step 3: If the new patient paid amount is greater than the amount calculated for the "You May Be Billed" column, subtract the original "You May Be Billed" amount for the first service line from the new patient paid amount, and show zero in the "You May Be Billed" column.

Repeat these steps with any remaining beneficiary paid amounts.

2. Unassigned Claims

If an unassigned claim is submitted with a beneficiary paid amount, the amount(s) in the "You May Be Billed" column will be reduced by the amount the beneficiary prepaid the provider. Apply the beneficiary paid amount for each service line sequentially until the beneficiary paid amount is reduced to zero or all service lines have been considered.

Step 1: If the amount the beneficiary paid is less than or equal to the amount calculated for the “You May Be Billed” column, subtract the amount the beneficiary paid from that amount, and display the difference in the “You May Be Billed” column for that service line.

Step 2: If the amount the beneficiary paid amount is less than or equal to the amount calculated for the “You May Be Billed” column, subtract the “You May Be Billed” amount for the first service line from the amount the beneficiary paid, and show zero in the “You May Be Billed” column for that service line.

Repeat these steps with any remaining beneficiary paid amounts.

If there is a balance after all service lines have been considered on unassigned claims, that amount is what the beneficiary overpaid the provider. Carriers have the option of printing claim level message 34.3 *(use the hyperlink to the MSN message file in §50)* in this situation if their system permits.

Print message 34.2 on assigned claims when the beneficiary paid amount does not exceed coinsurance and deductible and for all unassigned claims submitted with a beneficiary paid amount.

EXAMPLE 1: Assigned claim - beneficiary paid amount equals $35.00

Show the "You May Be Billed" amounts after calculations in §10.3.10.2 but prior to reduction for beneficiary paid amount (steps 1, 2 and 3 above). See Example 2 for results after step 1, 2, and 3 have been applied.

Dates of Service	Services Provided	Amount Charged	Medicare Approved	Medicare Paid Provider	You May Be Billed	See Notes Section
John Smith, M.D. **123 West Street** **Jacksonville, FL 32231**						
06/06/97	1 Eye Refraction (92015)	$22.00	$0.00	$0.00	$22.00	b
06/06/97	1 Eye Exam & Treatment (92014)	$51.16	$51.16	$40.93	$10.23	
06/06/97	1 Visual Field Exam (92081)	$21.54	$21.54	$17.23	$4.31	
Claim Total		$94.70	$72.70	$58.16	$36.54	a

Notes Section:

a. Of the total $58.16 paid on this claim, Medicare is paying you $20.46 because you paid your provider more than your 20 percent coinsurance on Medicare approved services. The remaining $37.70 was paid to the provider.

b. Eye refractions are not covered.

EXAMPLE 2: Assigned claim - beneficiary paid amount equals $35.00

This example shows example 1 after steps 1, 2, and 3 have been applied.

Dates of Service	Services Provided	Amount Charged	Medicare Approved	Medicare Paid Provider	You May Be Billed	See Notes Section
John Smith, M.D. 123 West Street Jacksonville, FL 32231						
06/06/97	1 Eye Refraction (92015)	$22.00	$0.00	$0.00	$7.46	b.
06/06/97	1 Eye Exam & Treatment (92014)	$51.16	$51.16	$40.93	$10.23	
06/06/97	1 Visual Field Exam (92081)	$21.54	$21.54	$17.23	$4.31	
Claim Total		$94.70	$72.70	$58.16	$22.00	a

Notes Section:

a. Of the total $58.16 paid on this claim, Medicare is paying you $20.46 because you paid your provider more than your 20 percent coinsurance on Medicare approved services. The remaining $37.70 was paid to the provider.

b. Eye refractions are not covered.

Explanation of Example 2

The beneficiary check amount of $20.46 is subtracted from the $35.00 patient paid amount submitted on the claim leaving a difference of $14.54. The new patient-paid amount is $14.54.

The $14.54 is subtracted from the $22.00 beneficiary liability from service line 1. The difference is displayed in the “You May Be Billed” column for service line 1.

G. Display of the “Medicare Paid You” Column for Unassigned Claims with a Previous Overpayment Amount Withheld

The “Medicare Paid You” column should show the actual amount that would have been paid if no previous overpayment had been withheld from the check issued to the

beneficiary. Use message 32.1 to show the amount by which the check is reduced to recover an overpayment from the beneficiary.

H. Display of the "Medicare Paid You" Column for Assigned and Unassigned Adjustment Claims

Show all service lines for the adjustment claim. The "Medicare Approved" and "Medicare Paid" columns will display the same allowed and paid amounts as were shown on the original MSN for service lines that are not subject to adjustment.

The "Medicare Approved" and "Medicare Paid" columns for adjusted service lines will show the total combined amount approved and paid for both the original and adjusted claim. Likewise, "Claim Total" lines for adjusted claims will reflect the combined total amounts approved and paid for the original and adjusted claim.

The "You May Be Billed" column will show the beneficiary's total responsibility. The contractor uses message 31.13 on all adjustments where a partial payment was previously made.

20.6 - Appeals Section

(Rev.1491, Issued: 04-11-08, Effective: 05-12-08, Implementation: 05-12-08)

ENGLISH - Appeals Information - Part B

SPANISH - Información de Apelaciones - Parte B

Fiscal intermediary Only ENGLISH - If you disagree with any claims decisions on either Part A or Part B of this notice, your appeal must be received by (_____). Follow the instructions below:

Fiscal intermediary Only SPANISH - Si usted no está de acuerdo con cualquier decisión en la Parte A o la Parte B de esta notificación, debemos recibir su apelación antes de (_____). Siga las instrucciones indicadas abajo:

Carrier Only ENGLISH - If you disagree with any claims decision on this notice, your appeal must be received by (_____). Follow the instructions below:

Carrier Only SPANISH - Si usted no está de acuerdo con cualquier decisión en esta notificación, debemos recibir su apelación antes de (_____). Siga las instrucciones indicadas abajo:

ENGLISH - Circle the item(s) you disagree with and explain why you disagree.

SPANISH - Indique con un círculo los detalles con los que usted no está de acuerdo y explique la razón.
ENGLISH - Send this notice, or a copy, to the address in the Customer Service Information box on page 1. (You may also send any additional information you may have about your appeal.)

SPANISH - Envíe esta notificación o una copia a la dirección indicada en la sección Información de Servicios al Cliente en la página 1. (Usted también puede enviar cualquier información adicional que tenga sobre su apelación.)

ENGLISH - Sign here _____ Phone Number (____)_____

SPANISH - Firme aquí _____ Su número de teléfono (____) _____

The DME MACs shall change the Appeals Information section of the MSN to read as follows:

If you disagree with any claims decisions on this notice, your appeal must be received by (appeal date). Follow the instructions below:

1) Circle the item(s) you disagree with and explain why you disagree.

2) Send this notice, or a copy, to the following address:(**INSERT YOUR *DME MAC* ADDRESS)**(You may also send any additional information you may have about your appeal.)

3) Sign here_____ Phone number ( )_____

The *DME MACs* shall make these changes for both English and Spanish MSNs.

The Spanish translation for "Send this notice, or a copy, to the following address" is: Envíe esta notificación, o una copia, a la dirección siguiente.

The *DME MAC* appeals address should start on the same line immediately following the colon after the phrase "Send this notice, or a copy, to the following address:"

The J3 MAC and all future MACs shall change the Appeals Information section of the MSN to read as follows:

If you disagree with any claims decisions on this notice, your appeal must be received by (appeal date). Follow the instructions below:

1) Circle the item(s) you disagree with and explain why you disagree.

3) Send this notice, or a copy, to the following address: (**INSERT YOUR MAC ADDRESS)** (You may also send any additional information you may have about your appeal.)

4) Sign here_____ Phone number ( )_____

The J3 MAC and all future MACs shall make these changes for both English and Spanish MSNs.

The Spanish translation for “Send this notice, or a copy, to the following address” is: Envíe esta notificación, o una copia, a la dirección siguiente.

The MAC appeals address should start on the same line immediately following the colon after the phrase “Send this notice, or a copy, to the following address:”

30.1 - Intermediary Exhibits

(Rev.1491, Issued: 04-11-08, Effective: 05-12-08, Implementation: 05-12-08)

The following exhibits show the MSN format, the back of the notice and selected displays. They provide a reference point for use in generating the format of the MSN. The data displayed in the exhibits is for illustration purpose only. *The dates, the deductible and the coinsurance have not been updated.*

The following exhibits are presented as separate files in PDF format. To return here from the PDF file, just close the PDF file.

Exhibit 1 - Inpatient/Outpatient Combined
Exhibit 2 - Back of Notice Outpatient and Inpatient Combined
Exhibit 3 - Outpatient Psychiatric Services
Exhibit 4 - Deductible Applied
Exhibit 5 - Noncovered Service (Beneficiary is liable.)
Exhibit 6 - Split Pay Claim, Patient Paid, 100 Percent Services
Exhibit 7 - MSP Situations
Exhibit 8 - MSP With Noncovered Charge
Exhibit 9 - MSP (Cost Avoided)
Exhibit 10 - MSP (Partial Recovery - Beneficiary Has Some Liability Remaining)
Exhibit 11 - MSP (Full Recovery - Beneficiary Has No Liability Remaining)
Exhibit 12 - Home Health
Exhibit 13 - Hospice
Exhibit 14 - Spanish Inpatient/Outpatient Combined
Exhibit 15 - Spanish Back of Notice

30.2 - Carrier Exhibits

(Rev.1491, Issued: 04-11-08, Effective: 05-12-08, Implementation: 05-12-08)

The following exhibits show the MSN format, the back of the notice and selected displays. They provide a reference point for use in generating the format of the MSN. The data displayed in the exhibits is for illustration purpose only. *The dates, the deductible and the coinsurance information have not been updated.*

These are separate files in PDF format. To return here from the PDF file, just close the PDF file.

Exhibit 1 - Limiting Charge/Interest to the Beneficiary
Exhibit 2 - Outpatient Psychiatric Services Paid at 50 Percent
Exhibit 3 - Multiple Years of Service
Exhibit 4 - Assigned/Unassigned DME Rental
Exhibit 5 - Assigned - 10-Percent Late Filing Reduction
Exhibit 6 - Payment to Beneficiary on an Assigned Claim
Exhibit 7 - Medicare Secondary Payment
Exhibit 8 - Medicare Secondary Payment with Beneficiary Liability
Exhibit 9 - Back of Notice
Exhibit 10 - Spanish
Exhibit 11 - Spanish Back of Notice

40 - Explanatory and Denial Messages

(Rev.1491, Issued: 04-11-08, Effective: 05-12-08, Implementation: 05-12-08)

The purpose of the MSN messages is to concisely communicate essential information to the beneficiary regarding claim determinations or to serve as an educational tool.

The MSN message file is found at the hyperlink in §50. Messages are grouped in categories for ease of reference only. Unless specific messages are specified in instructions by CMS, contractors should select and use the most appropriate message(s) for each situation to explain the action taken on a service, item, or claim. Contractors are instructed to use the most appropriate message for each situation regardless of message category.

Use multiple messages as appropriate including ones grouped within different categories. Use the message(s) which best explains the situation(s) in the claim.

All denied or reduced services must have an explanation.

The BBA of 1997 requires the amount of Medicare payment for each service be included on all Part A Benefit notices, including the MSN and Notice of Utilization (NOU.) Contractors use message 16.53 on all intermediary generated notices with payments.

The contractor may combine “add-on” messages with existing messages to create a single message within its file.

Each message on the file is tied to an alphabetic code on the MSN. Print no more than three alphabetic codes per claim level and three alphabetic codes per service line.

Messages containing fill-in blanks may be left as blanks for filling in by the system or may be entered into the system with blanks pre-filled to create as many specific messages as there are fill-in situations.

The message numbering in this section does not have to be used in contractor message generating systems.

Certain messages are mandated. These messages and the situations for which they are mandated are identified in *the MSN message file at the hyperlink in §50*. This does not eliminate the need to use other messages required by instructions elsewhere in the manual.

Beneficiary liability "Add-on" messages should be printed in addition to denial and reduction messages for charges which the beneficiary is determined not liable. Liability "Add-on" messages should print for denials or reductions such as:

- Services that are part of another service or bundled code;

- Services determined not to be medically necessary in situations where the beneficiary was not notified in writing, prior to receipt of the service, that Medicare may not make payment;

- Duplicate charges; and

- Denials for utilization reasons.

50 - Categories and Identification Numbers for Approved MSN Messages *– English Messages*

(Rev.1491, Issued: 04-11-08, Effective: 05-12-08, Implementation: 05-12-08)

MSN messages *in the MSN message file in §50* are separated into the following categories. Within each category, messages are numbered beginning with 1 (e.g., ambulance messages are from 1.1 through 1.11; blood messages are from 2.1 through 2.2). Each MSN has a unique number when the category number is included. Numbers are the same for carriers and intermediaries, including *DME MACs* and RHHIs. However, the message number is not printed on the MSN, and contractors are free to use any internal numbering system appropriate for their systems.

Contractors are instructed to use the most appropriate message for each situation regardless of message category. The categories are to facilitate reference.

1 - Ambulance

2 - Blood
3 - Chiropractic
4 - End-Stage Renal Disease (ESRD)
5 - Number/Name/Enrollment
6 - Drugs
7 - Duplicate Bills
8 - Durable Medical Equipment (DME)
9 - Failure to Furnish Information
10 - Foot Care
11 - Transfer of Claims or Parts of Claims
12 - Hearing Aids
13 - Skilled Nursing Facility
14 - Laboratory
15 - Medical Necessity
16 - Miscellaneous
17 - Non Physician Services
18 - Preventive Care
19 - Hospital Based Physician Services
20 - Benefit Limits
21 - Restrictions to Coverage
22 - Split Claims
23 - Surgery
24 - “Help Stop Fraud” messages
25 - Time Limit for Filing
26 - Vision
27 - Hospice
28 - Mandatory Assignment for Physician Services Furnished Medicaid Patients
29 - Medicare Secondary Payer (MSP)
30 - Reasonable Charge and Fee Schedule
31 - Adjustments
32 - Overpayments/Offsets
33 - Ambulatory Surgical Centers
34 - Patient Paid/Split Payments
35 - Supplemental Coverage/Medigap
36 - Limitation of Liability
37 - Deductible/Coinsurance
38 - General Information
39 - Add-on Messages

41 - Home Health Messages
42 - Religious Nonmedical Health Care Institutions
43 - Demonstration Project Messages

NOTE: *Mandated messages are noted as such in the MSN file.*

English messages can be found at the following url:

www.cms.hhs.gov/MSN

90 - Spanish Messages

(Rev.1491, Issued: 04-11-08, Effective: 05-12-08, Implementation: 05-12-08)

Spanish messages can be found at the following url:

www.cms.hhs.gov/MSN