CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1588	**Date: SEPTEMBER 5, 2008**
	Change Request 5683

Transmittal 1557, dated July 18, 2008, is rescinded and replaced by Transmittal 1588 to clarify in the Business Requirements that this CR applies to all claims received on or after the implementation date regardless of the date of service.

SUBJECT: Beneficiary Submitted Claims

I. SUMMARY OF CHANGES: These changes update the procedures for processing claims submitted by Medicare beneficiaries to A/B MACs and/or carriers. These changes do not apply to beneficiary claims submitted to DME MACs.

New / Revised Material
Effective Date: August 18, 2008
Implementation Date: August 18, 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	1/Table of Contents
R	1/70.5/Application to Special Claim Types
R	1/70.8.8.6/Monitoring Claims Submissions Violations
R	1/70.8.8.7Notification Letters
R	1/80.3.1/Incomplete or Invalid Claims Processing Terminology
R	1/80.3.2/Hnadling Incomplete or Invalid Claims
R	27/20.2.2.2/Disposition Code 51 (True Not In File On CMS Batch System)
R	27/20.2.2.6/Disposiotion Code 55 (Personal Characteristic Mismatch)

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

Transmittal 1557, dated July 18, 2008, is rescinded and replaced by Transmittal 1588 to clarify in the Business Requirements that this CR applies to all claims received on or after the implementation date regardless of the date of service.

Pub. 100-04	Transmittal: 1588	Date: September 5, 2008	Change Request: 5683

SUBJECT: Beneficiary Submitted Claims

Effective Date: August 18, 2008
Implementation Date: August 18, 2008
(**NOTE:** This CR applies to all claims received on or after the implementation date regardless of the date of service.)

I. GENERAL INFORMATION

A. Background: All providers and suppliers are required to enroll in the Medicare program in order to receive payment. In addition, Section 1848 (g)(4)(A) of the Social Security Act requires all providers and suppliers to submit claims for services rendered to Medicare beneficiaries. The current manual requirement instructs Medicare contractors to provide education to the providers and suppliers explaining the statutory requirement, including possible penalties for repeatedly refusing to submit claims for services provided.

B. Policy:

Medicare contractors shall:

1) Process beneficiary submitted claims for services that are not covered by Medicare (e.g., for hearing aids, cosmetic surgery, personal comfort services, etc.; see 42 CFR 411.15 for details), in accordance with its normal processing procedures;

2) Process beneficiary submitted claims for services that are covered by Medicare when the beneficiary has submitted a complete claim (Form CMS-1490S) and all supporting documentation associated with the claim, including an itemized bill with the following information, date of service, place of service, description of illness or injury, description of each surgical or medical service or supply furnished, charge for each service, the doctor's or supplier's name, address, and the provider or supplier's National Provider Identifier. If an incomplete claim or a claim containing invalid information is submitted, the contractor shall manually return the claim as incomplete with an appropriate letter. CMS will be providing suggested language for that letter in a later CR. Manually return beneficiary submitted claims on Form CMS-1500 to the beneficiary with instructions how to complete and return Form CMS-1490S for processing.

3) When manually returning a beneficiary submitted claim (Form CMS-1490S) for a Medicare-covered service because the claim is not complete or contains invalid information, the contractor shall maintain a record of the beneficiary-submitted claim for purposes of the timely filing rules in the event that the beneficiary re-submits the claim (see below).

When returning a beneficiary submitted claim, the contractor shall also inform the beneficiary, by letter, that the provider or supplier is required by law to submit a claim on behalf of the beneficiary (for services that would otherwise be payable), and that in order to submit the claim, the provider must enroll

in the Medicare program. In addition, contractors should encourage beneficiaries to always seek non-emergency care from a provider or supplier that is enrolled in the Medicare program.

If a beneficiary receives services from a provider or supplier that refuses to submit a claim on the beneficiary's behalf (for services that would otherwise be payable by Medicare), the beneficiary should:

(1) Notify the contractor in writing that the provider or supplier refused to submit a claim to Medicare, and

(2) Submit a complete Form CMS-1490S with all supporting documentation.

Upon receipt of both the beneficiary's complaint that the provider/supplier refused to submit the claim, and the submission of Form CMS-1490S and all supporting documentation, the contractor shall process and pay the beneficiary's claim if it is for a service that would be payable by Medicare were it not for the provider's or supplier's refusal to submit the claim and/or enroll in Medicare. Contractors shall maintain documentation of beneficiary complaints involving violations of the mandatory claims submission policy and a list of the top 50 violators, by State, of the mandatory claim submission policy.

The following instructions do not apply to foreign claims. The processing of foreign claims shall remain unchanged. The following instructions also do not apply to beneficiary claims submitted to DMEMACs for durable medical equipment, prosthetics, orthotics and supplies. DMEMACs should continue to follow the procedures currently in place.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
5683.1	Contractors shall not apply the Business Requirements in this CR to foreign or DMEPOS claims.	X	X		X						
5683.1.1	Contractors shall continue to process foreign and DMEPOS claims per current CMS instructions.	X	X		X						
5683.1.2	Contractors shall process foreign and DMEPOS beneficiary claims in accordance with normal processing procedures.	X	X		X						
5683.2	Contractors shall process a beneficiary claim for covered services and/or non-covered services when the beneficiary submits a complete claim (Form CMS-1490S) and all supporting documentation.	X			X						
5683.2.1	Contractors shall consider a complete claim to have all items on the CMS-1490S completed along with an itemized bill with the following information: date of service, place of service, description of each surgical or medical service or supply furnished; charge for each service; treating doctor's or supplier's name and address; diagnosis code; procedure code; and the provider or	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	
	supplier's National Provider Identifier. Required information on a claim must be valid for the claim to be considered as complete.										
5683.2.2	Contractors shall also notify the provider or supplier through a letter about his/her obligation to submit claims on behalf of Medicare beneficiaries and that providers and suppliers are required to enroll in the Medicare program to receive reimbursement.	X			X						
5683.2.3	Until such time as CMS provides suggested language for these letters, contractors shall create their own language to be used in the letters.	X			X						
5683.3	Contractors shall manually return a beneficiary claim for covered services when the beneficiary submits an incomplete claim and/or a claim that lacks the required supporting documentation. Note: This Change Request supersedes the Business Requirements 5770.1.3 and 5770.1.3.1 of CR 5770, Transmittal 1399, concerning development for the correct HICN on Form CMS-1490S claims.	X			X						
5683.3.1	Contractors shall send a letter to the beneficiary with information explaining the mandatory claims filing requirements; instructions for resubmitting the claim if the provider or supplier refuses to file the claim; what information is missing on the claim that was submitted; and shall include language encouraging the beneficiary to seek non-emergency care from a provider or supplier that is enrolled in the Medicare program.	X			X						
5683.3.2	Contractors shall also notify the provider or supplier about his/her obligation to submit claims on behalf of Medicare beneficiaries and that providers and suppliers are required to enroll in the Medicare program to receive reimbursement.	X			X						
5683.3.3	Until such time as CMS provides suggested language for these letters, contractors shall create their own language to be used in the letters.	X			X						
5683.4	Upon receipt of both the beneficiary's complaint that the provider/supplier refused to submit the claim, and the resubmission of the complete Form CMS-1490S and all supporting documentation, contractors shall process and pay the beneficiary's claim if it is for a service that would be payable by Medicare were it not for the provider's or supplier's refusal to submit the claim and/or enroll in Medicare.	X			X						
5683.4.1	Contractors shall process the claim in accordance with	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	
	Pub. 100-04, chapter 1 sections 70.8.8.6 and 70.8.8.7 concerning timely filing.										
5683.4.2	Contractors shall maintain documentation of beneficiary complaints involving violations of the mandatory claims submission policy and a list of the top 50 violators, by State, of the mandatory claim submission policy.	X			X						
5683.5	Contractors shall manually return a beneficiary submitted Form CMS-1500 claim to the beneficiary with instructions explaining how to resubmit the claim on the Form CMS-1490S if the provider or supplier refuses to file a Form CMS-1500 claim.	X			X						
5683.6	Contractors shall recognize and process the Form CMS-1490S in accordance with Pub. 100-04, chapter 27 section 20.2.2.2 concerning Disposition Code 51 and chapter 27 section 20.2.2.2 concerning Disposition Code 55.	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	
5683.7	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X			X						

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
5683.3	This Change Request supersedes the Business Requirements 5770.1.3 and 5770.1.3.1 of CR 5770, Transmittal 1399, concerning development for the correct HICN on Form CMS-1490S claims.

Section B: For all other recommendations and supporting information, use this space:
The procedures described in the CR are to be applied to all claims received on or after the implementation date of the CR regardless of the date of the service.

V. CONTACTS

Pre-Implementation Contact(s): Allen Gillespie 410-786-5996 Allen.Gillespie@cms.hhs.gov

Post-Implementation Contact(s): Allen Gillespie 410-786-5996 Allen.Gillespie@cms.hhs.gov or Sandra Olson 410-786-1325 Sandra.Olson@cms.hhs.gov

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs) 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.

Medicare Claims Processing Manual

Chapter 1 – General Billing Requirements

(Rev. 1588, 09-05-08)

70.5 - Application to Special Claim Types

(Rev. 1588; Issued: 09-05-08; Effective/Implementation Date: 08-18-08)

- Adjustments - If a provider fails to include a particular item or service on its initial claim, an adjustment submission to include such an item(s) or service(s) is not permitted after the expiration of the time limitation for filing of the initial claim. There is no longer timely filing period for adjustments. There are special timeliness requirements for filing adjustment requests for inpatient services subject to a prospective payment system, if the adjustment results in a change to a higher weighted DRG. These adjustments must be submitted within 60 days of the date of the remittance for the original claim, or the adjustment will be rejected.

  However, to the extent that an adjustment bill otherwise corrects or supplements information previously submitted on a timely claim about specified services or items furnished to a specified individual, it is subject to the rules governing administrative finality, rather than the time limitation for filing (see Chapter 29 on Reopenings).

- Emergency Hospital Services and Services Outside the United States - The time limit for claims for payment for emergency hospital services and hospital services outside the United States, whether or not the hospital has elected to bill the program, is the same as for participating hospitals. (See §70.1 above.) The claim for emergency hospital services and other services outside the United States will be considered timely filed if filed with any intermediary within the time limit.

- *If a beneficiary submits an initial claim within the timely filing period for payment of services on the Form CMS-1490S and the claim is incomplete and/or does not include an itemized bill containing the information required by the Form CMS-1490S instructions or contains invalid information and the claim is returned to the beneficiary for completion or correction, consider the original claim submission by the beneficiary to extend the timely period for submission of a complete claim. A completed Form CMS-1490S claim that meets the requirements for the claim must be submitted to the appropriate Medicare contractor within 6 months after the month in which the Medicare contractor notified (see §70.8.8.6 and §70.8.8.7 below) the party who submitted the claim that the claim was incomplete or a complete claim must be submitted by the end of the applicable timely filling period, whichever is later. Apply these same timely filing procedures to Form CMS-1500 claims submitted by beneficiaries. In these cases, a complete Form CMS-1490S and itemized bill must be submitted within the above timeframes*.

70.8.8.6 – *Monitoring Claims Submission Violations*

(Rev. 1588; Issued: 09-05-08; Effective/Implementation Date: 08-18-08)

A. General

Section 1848(g)(4) of the Social Security Act requires physicians and suppliers to submit claims to Medicare carriers for services furnished on or after September 1, 1990. It also prohibits physicians and suppliers from imposing a charge for completing and submitting a claim. Payment for assigned services not filed within 1 year (for services on or after 9/1/90) are reduced 10 percent. Physicians and suppliers who fail to submit a claim or who impose a charge for completing the claim are subject to sanctions. CMS is responsible for assessing sanctions and monetary penalties for noncompliance.

Physicians and suppliers are not required to take assignment of Medicare benefits unless they are enrolled in the Medicare Participating Physician and Supplier Program or, in the case of physician services, the Medicare beneficiary is also a recipient of State medical assistance (Medicaid) or the service is otherwise subject to mandatory assignment.

B. ***Compliance Monitoring***

To ensure that providers and suppliers are enrolled in the Medicare program and submit claims in compliance with the mandatory claims submission requirements found in §1848(g)(4) of the Social Security Act, contractors shall:

1) *Process beneficiary claims submitted to A/B MACs or carriers for services that are not covered by Medicare (e.g., for hearing aids, cosmetic surgery, personal comfort services, etc.; see 42 CFR 411.15 for details), in accordance with its normal processing procedures;*

2) *Process beneficiary claims submitted to A/B MACs or carriers for services that are covered by Medicare and the beneficiary has submitted a complete and valid claim (Form CMS-1490S) and all supporting documentation associated with the claim, including an itemized bill with the following information, date of service, place of service, charge for each service, the doctor's or supplier's name, address, and the provider or supplier's National Provider Identifier. If a beneficiary submits a claim on the Form CMS-1500, manually return the Form CMS-1500 claim to the beneficiary, and include a copy of the Form CMS-1490S, along with a letter instructing the beneficiary to complete and return the Form CMS-1490S for processing within the time period prescribed in §70.5, above. Include in the letter a description of missing, invalid or incomplete items required for the Form CMS-1490S that were not included with the submitted Form CMS-1500 or were invalid.*

3) *Return as incomplete to the beneficiary, a beneficiary submitted claim submitted to an A/B MAC or carrier (Form CMS-1490S) for a Medicare-covered service if the claim is not complete or does not include all required supporting documentation or contains invalid information. In addition, the contractor shall maintain a record of the beneficiary-submitted claim for purposes of the timely filing rules in the event that the beneficiary re-submits the claim (see below). If a beneficiary submits a claim on the Form CMS-1500, return the Form CMS-1500 claim to the beneficiary, and include a copy of the Form CMS-1490S, along with*

a letter instructing the beneficiary to complete and return the Form CMS-1490S for processing within the time period prescribed in §70.5 above. Include in the letter a description of missing, invalid or incomplete items required for the Form CMS-1490S that were not included with the submitted Form CMS-1500 or were invalid.

When returning a beneficiary submitted claim, the contractor shall inform the beneficiary that the provider or supplier is required by law to submit a claim on behalf of the beneficiary (for services that would otherwise be payable), and that in order to submit the claim, the provider must enroll in the Medicare program. In addition, contractors shall encourage beneficiaries to always seek non-emergency care from a provider or supplier that is enrolled in the Medicare program.

If a beneficiary receives services from a provider or supplier that refuses to submit a claim to the A/B MAC or carrier, on the beneficiary's behalf, (for services that would otherwise be payable by Medicare), the beneficiary should:

(1) Notify the contractor in writing that the provider or supplier refused to submit a claim to Medicare, and

(2) Submit a complete Form CMS-1490S with all supporting documentation.

Upon receipt of both the beneficiary's complaint that the provider/supplier refused to submit the claim, and the submission of Form CMS-1490S and all supporting documentation, the contractor shall process and pay the beneficiary's claim if it is for a service that would be payable by Medicare were it not for the provider's or supplier's refusal to submit the claim and/or enroll in Medicare. Contractors shall maintain documentation of beneficiary complaints involving violations of the mandatory claims submission policy and a list of the top 50 violators, by State, of the mandatory claim submission policy.

Contractors are encouraged to educate providers and suppliers that they must be enrolled in the Medicare program before they submit claims for services furnished or supplied to any Medicare beneficiary.

The above policy is not applicable for foreign beneficiary claims submitted for covered services. These claims should be processed using guidelines for foreign claims.
The above policy is not applicable to beneficiary claims submitted to DMEMACs for durable medical equipment, prosthetics, orthotics, and supplies. These claims should be processed by DMEMACs using current procedures.

C. Exception When Physician, Other Practitioner, or Supplier Is Excluded From Participating in Medicare Program

Section 1848(g)(4) of the Social Security Act requires physicians, other practitioners, or suppliers to submit claims to Medicare carriers for services furnished after September 1,

1990. This **does not** apply to physicians, other practitioners, or suppliers who have been excluded from participating in the Medicare program. Physicians, other practitioners, and suppliers who have been excluded from the Medicare program are prohibited from submitting claims or causing claims to be submitted. See the Medicare Program Integrity Manual for procedures concerning claims submitted by an excluded practitioner, his/her employer, or a beneficiary for services or items provided by an excluded physician, other practitioner, or supplier. Carriers must maintain the systems capability to identify claims submitted by excluded physicians, other practitioners, or suppliers as well as items or services provided, ordered, prescribed, or referred by an excluded party.

When an excluded physician, other practitioner, or supplier has not submitted a claim on behalf of the beneficiary and/or the beneficiary has submitted the claim themselves, do **not** send a notification letter to the physician, other practitioner, or supplier warning of civil monetary penalties due to noncompliance with §1848(g)(4)(A) of the Act. Instead, follow the instructions in the Program Integrity Manual.

70.8.8.7 - *Notification Letters*

(Rev. 1588; Issued: 09-05-08; Effective/Implementation Date: 08-18-08)

A. *The letter sent to the beneficiary should explain why the claim is being returned including an explanation of the corrections needed in order to process the claim. Also, include an explanation of the statutory requirement that providers and suppliers must submit claims for all covered services provided to Medicare beneficiaries. The letter should also provide the beneficiary with instructions on what should be done if the provider or supplier refuses to enroll with Medicare and/or submit the claim.*

B. *A letter shall also be sent to the provider or supplier explaining the statutory requirement for submitting claims for all services rendered to Medicare beneficiaries. The letter should explain to the provider or supplier that they are required to enroll with the Medicare program before a claim can be submitted. Finally the letter should include language explaining the penalties for failure to comply with the mandatory claims submission requirements.*

80.3.1 - Incomplete or Invalid Claims Processing Terminology

(Rev. 1588; Issued: 09-05-08; Effective/Implementation Date: 08-18-08)

The following definitions apply to §80.3.2. For carriers the requirements apply to Part B assigned and unassigned claims (Form CMS-1500) or electronic data interchange equivalent.

Unprocessable Claim - Any claim with incomplete or missing, required information, or any claim that contains complete and necessary information; however, the information provided is invalid. Such information may either be required for all claims or required conditionally.

Incomplete Information - Missing, required or conditional information on a claim (e.g., no Unique Physician Identification Number (UPIN) / Provider Identification Number (PIN) or National Provider Identifier (NPI) when effective).

Invalid Information - Complete required or conditional information on a claim that is illogical, or incorrect (e.g., incorrect UPIN/PIN or NPI when effective), or no longer in effect (e.g., an expired number).

Required - Any data element that is needed in order to process a claim (e.g., Provider Name, Date of Service).

Not Required - Any data element that is optional or is not needed by Medicare in order to process a claim (e.g., Patient's Marital Status).

Conditional - Any data element that must be completed if other conditions exist (e.g., if there is insurance primary to Medicare, then the primary insurer's group name and number must be entered on a claim or if the insured is different from the patient, then the insured's name must be entered on a claim).

Return as Unprocessable or Return to Provider (RTP)- Returning a claim as unprocessable to the provider (RTP) does not mean that the carrier or FI should physically return every claim it received with incomplete or invalid information. The term "return to provider" is used to refer to the many processes utilized today for notifying the provider or supplier of service that their claim cannot be processed, and that it must be corrected or resubmitted. Some (not all) of the various techniques for returning claims as unprocessable include:

- Incomplete or invalid information is detected at the front-end of the carrier or FI claims processing system. The claim is returned to the provider (RTP'd) either electronically or in a hardcopy/checklist type form explaining the error(s) and how to correct the errors prior to resubmission. Claim data are not retained in the system for these RTP'd claims. No RA is issued.

- Incomplete or invalid information is detected at the front-end of the claims processing system and is suspended and developed. If requested corrections and/or medical documentation are submitted within a 45-day period, the claim is processed. Otherwise, the suspended portion is returned and the supplier or provider of service is notified by means of the RA.

- Incomplete or invalid information is detected within the claims processing system and is rejected through the remittance process. Suppliers or providers of service are notified of any error(s) through the remittance notice and how to correct prior to resubmission. A record of the claim is retained in the system (**NOTE:** This applies to carriers only. FIs do not use the remittance advice process for return to provider (RTP)).

A claim returned as unprocessable for incomplete or invalid information does not meet the criteria to be considered as a claim, is not denied, and, as such, is not afforded appeal rights.

80.3.2 - Handling Incomplete or Invalid Claims

(Rev. 1588; Issued: 09-05-08; Effective/Implementation Date: 08-18-08)

Claims processing specifications describe whether a data element is required, not required, or conditional (a data element which is required when certain conditions exist). The status of these data elements will affect whether or not an incomplete or invalid claim (hardcopy or electronic) will be "returned as unprocessable" or "returned to provider" (RTP) by the carrier or FI, respectively. The carrier or FI *shall* not deny claims and afford appeal rights for incomplete or invalid information as specified in this instruction. (See §80.3.1 for Definitions.)

If a data element is required and it is not accurately entered in the appropriate field, the carrier or FI returns the claim to the provider of service.

- If a data element is required, or is conditional (a data element that is required when certain conditions exist) and the conditions of use apply) and is missing or not accurately entered in its appropriate field, return as unprocessable or RTP the claim to either the supplier or provider of service.

- If a claim must be returned as unprocessable or RTP for incomplete or invalid information, the carrier or FI must, at minimum, notify the provider of service of the following information:

    - Beneficiary's Name;

    - Claim Number; HIC Number or HICN or Health Insurance Claim Number. This has never been HI Claim Number.

    - Dates of Service (MMDDCCYY) (Eight-digit date format effective as of October 1, 1998);

    - Patient Account or Control Number (only if submitted);

    - Medical Record Number (FIs only, if submitted); and

    - Explanation of Errors (e.g., Remittance Advice Reason and Remark Codes)

NOTE: Some of the information listed above may in fact be the information missing from the claim. If this occurs, the carrier or FI includes what is available.

Depending upon the means of return of a claim, the supplier or provider of service has various options for correcting claims returned as unprocessable or RTP for incomplete or invalid information. They may submit corrections either in writing, on-line, or via telephone when the claim was suspended for development, or submit as a "corrected" new claim, or as an entirely new claim if data from the original claim was not retained in the system, as with a front-end return, or if a remittance advice was used to return the claim. The chosen mode of submission, however, must be currently supported and appropriate with the action taken on the claim.

NOTE: The supplier or provider of service must not be denied any services (e.g., modes of submission or customer service), other than a review, to which they would ordinarily have access.

- If a claim or a portion of a claim is "returned as unprocessable" or RTP for incomplete or invalid information, the carrier or FI does not generate an MSN to the beneficiary.

- The notice to the provider or supplier will not contain the usual reconsideration notice, but will show each applicable error code or equivalent message.

- If the carrier or FI uses an electronic or paper remittance advice notice to return an unprocessable claim, or a portion of unprocessable claim:

    1. The remittance advice must demonstrate all applicable error codes. However, there must be a minimum of two codes on the remittance notice (including code MA130).

    2. The returned claim or portion must be stored and annotated, as such, in history, if applicable. If contractors choose to suspend and develop claims, a mechanism must be in place where the carrier or FI can re-activate the claim or portion for final adjudication.

A. Special Considerations

- If a "suspense" system is used for incomplete or invalid claims, the carrier or FI will not deny the claim with appeal rights if corrections are not received within the suspense period, or if corrections are inaccurate. The carrier must return the unprocessable claim through the remittance process, without offering appeal rights, to the provider of service or supplier. The FI uses the RTP process.

- *For assigned and unassigned claims submitted by beneficiaries (Form CMS-1490S), that are incomplete or contain invalid information, contractors shall manually return the claims to the beneficiaries. Contractors shall send a letter to the beneficiary with information explaining which information is missing, incorrect or invalid; information explaining the mandatory claims filing requirements; instructions for resubmitting the claim if the provider or supplier refuses to file the claim; and shall include language encouraging the beneficiary*

to seek non-emergency care from a provider or supplier that is enrolled in the Medicare program. Contractors shall also notify the provider or supplier about his/her obligation to submit claims on behalf of Medicare beneficiaries and that providers and suppliers are required to enroll in the Medicare program to receive reimbursement.

Contractors shall consider a complete claim to have all items on the Form CMS-1490S completed along with an itemized bill with the following information: date of service, place of service, description of each surgical or medical service or supply furnished; charge for each service; treating doctor's or supplier's name and address; diagnosis code; procedure code and the provider or supplier's National Provider Identifier. Required information on a claim must be valid for the claim to be considered as complete.

If a beneficiary submits a claim on the Form CMS-1500, return the Form CMS-1500 claim to the beneficiary, and include a copy of the Form CMS-1490S, along with a letter instructing the beneficiary to complete and return the Form CMS-1490S for processing within the time period prescribed in §70.5 above. Include in the letter a description of missing, invalid or incomplete items required for the Form CMS-1490S that were not included with the submitted Form CMS-1500 or were invalid.

NOTE: Telephone inquiries are encouraged.

- The carrier or FI *shall* not return an unprocessable claim if the appropriate information for both "required" and "conditional" data element requirements other than an NPI when the NPI is effective is missing or inaccurate but can be supplied through internal files. Contractors shall not search their internal files if an NPI is missing or inaccurate. Contractors shall not search their internal files to correct missing or inaccurate "required" and "conditional" data elements required under Sections 80.3.2.1.1 through 80.3.2.1.3 and required for HIPAA compliance for claims governed by HIPAA.

- For either a paper or electronic claim, if all "required" and "conditional" claim level information that applies is complete and entered accurately, but there are both "clean" and "dirty" service line items, then split the claim and process the "clean" service line item(s) to payment and return as unprocessable the "dirty" service line item(s) to the provider of service or supplier**. NOTE:** This requirement applies to carriers only.

No workload count will be granted for the "dirty" service line portion of the claim returned as unprocessable. The "clean" service line portion of the claim may be counted as workload **only if it is processed through the remittance process**. Contractors must abide by the specifications written in the above instruction; return the "dirty" service line portion without offering appeal rights.

- Workload will be counted for claims returned as unprocessable through the remittance process. Under no circumstances should claims returned as unprocessable by means other than the remittance process (e.g., claims returned in the front-end) be reported in the carrier or FI workload reports submitted to CMS. The carrier or FI is also prohibited from moving or changing the action on an edit that will result in an unprocessable claim being returned through the remittance process. If the current action on an edit is to suspend and develop, reject in the front or back-end, or return in the mailroom, the carrier or FI must continue to do so. Workload is only being granted to accommodate those who have edits which currently result in a denial. As a result, workload reports should not deviate significantly from those reports prior to this instruction.

NOTE: Rejected claims are not counted as an appeal on resubmissions.

B. Special Reporting of Unprocessable Claims Rejected through the Remittance Process (Carriers Only):

Carriers must report "claims returned as unprocessable on a remittance advice" on line 15 (Total Claims Processed) and on line 14 (subcategory Non-CWF Claims Denied) of page one of your Form CMS-1565. Although these claims are technically not denials, line 14 is the only suitable place to report them given the other alternatives. In addition, these claims should be reported as processed "not paid other" claims on the appropriate pages (pages 2-9) of CROWD Form T for the reporting month in which the claims were returned as unprocessable through the remittance process. Also, carriers report such claims on Form Y of the Contractor Reporting of Operational and Workload Data (CROWD) system. They report the "number of such claims returned during the month as unprocessable through the remittance process" under Column 1 of Form Y on a line using code "0003" as the identifier.

If a supplier, physician, or other practitioner chooses to provide missing or invalid information for a suspended claim by means of a telephone call or in writing (instead of submitting a new or corrected claim), carriers do not report this activity as a claim processed on Form CMS-1565/1566. Instead, they subtract one claim count from line 3 of Form Y for the month in which this activity occurred.

EXAMPLE: Assume in the month of October 2001 the carrier returned to providers 100 claims as unprocessable on remittance advices. The carrier should have included these 100 claims in lines 14 and 15 of page 1 of your October 2001 Form CMS-1565. During this same month, assume the carrier received new or corrected claims for 80 of the 100 claims returned during the month. These 80 claims should have been counted as claims received in line 4 of your October 2001 Form CMS-1565 page one (and subsequently as processed claims for the reporting month when final determination was made).

Also, during October 2001, in lieu of a corrected claim from providers, assume the carrier received missing information by means of a telephone call or in writing for 5 out of the 100 claims returned during October 2001. This activity should not have been reported as

new claims received (or subsequently as claims processed when adjustments are made) on Form CMS-1565. On line 3 of Form Y for October 2001, the carrier should have reported the number 95 (From claims returned as unprocessable through the remittance process minus 5 claims for which the carrier received missing or invalid information by means of a telephone call or in writing.

For the remaining 15 claims returned during October 2001 with no response from providers in that same month, the carrier should have reported on the Form CMS-1565 or Form Y, as appropriate, any subsequent activity in the reporting month that it occurred. For any of these returned claims submitted as new or corrected claims, the carrier should have reported their number as receipts on line 4 of page one of Form CMS-1565. For any of these returned claims where the supplier or provider of service chose to supply missing or invalid information by means of a telephone call or in writing, the carrier should not have counted them again on Form CMS-1565, but subtracted them from the count of returned claims reported on line 3 of Form Y for the month this activity occurred.

C. Exceptions (Carrier Only)

The following lists some exceptions when a claim may not be "returned as unprocessable" for incomplete or invalid information.

Carriers shall not return a claim as unprocessable:

If a patient, individual, physician, supplier, or authorized person's signature is missing, but the signature is on file, or if the applicable signature requirements have been met, do not return a claim as unprocessable where an authorization is attached to the claim or if the signature field has any of the following statements (unless an appropriate validity edit fails):

Acceptable Statements for Form CMS-1500:

- For items 12, 13, and 31, "Signature on File" statement and/or a computer generated signature;

- For items 12 and 13, Beneficiary's Name "By" Representative's Signature;

For item 12, "X" with a witnessed name and address. (Chapter 26 for instructions.)

Medicare Claims Processing Manual

Chapter 27 - Contractor Instructions for CWF

(Rev. 1588, 09-05-08)

20.2.2.2 - Disposition Code 51 (True Not in File on CMS Batch System)

(Rev. 1588; Issued: 09-05-08; Effective/Implementation Date: 08-18-08)

The Host gives this response with a 08 Trailer and error code 5052. The CMS has performed an alpha search of its records and cannot locate the beneficiary's records. Alpha search is the process of searching for the records based on the first six positions of the surname. All beneficiaries with the same first six letters in their surnames are listed with their HICNs. The system checks for possible matches, including the possibility that numbers were transposed. This search is performed only if no match is found during the search by HICN.

This code can be given in two forms:

1. With Trailer 01 - Trailer 01 will contain a possible corrected HICN. The carrier or FI investigates the possible HICN and, if it believes the new HICN is for the same beneficiary, it resubmits the claim with the new HICN to the Host. The CWF will respond with the appropriate disposition code and any associated trailers for processing the claim.

2. Without Trailer 01 - This response indicates that after performing the alpha search operation, no match is found against the HICN submitted and CMS records. Since Medicare eligibility cannot be established, contractors shall return the claim to the provider as unprocessable and take the following actions:

- Contractors shall return to provider (RTP) Part A claims. Contractors shall not mail an MSN for these claims.

- Contractors shall return as unprocessable Part B claims. Contractors shall use Reason Code 140 (Patient/Insured health identification number and name do not match). Contractors shall not mail an MSN for these claims.

- *For assigned and* unassigned Part B claims submitted by the beneficiary on the Form CMS-1490S *or Form CMS-1500,* contractors shall *manually return the claim in accordance with Pub.100-04, chapter 1, section 80.3.2 A. "Special Considerations."*

20.2.2.6 - Disposition Code 55 (Personal Characteristic Mismatch)

(Rev. 1588; Issued: 09-05-08; Effective/Implementation Date: 08-18-08)

- The Host provides the Satellite with this disposition code and Trailer 08 with error code 5052 when it discovers a mismatch of name and personal characteristics such as sex or date of birth.

- The Host returns what it believes to be the proper information on Trailer 10. The header portion of the response also contains the corrected sex and birth date, if applicable.

If CWF rejects a claim and sends back disposition code 55 with the 08 trailer containing Error Code 5052 when the beneficiary name does not match the HICN, contractors shall return the claim to the provider as unprocessable and take the following actions:

- Contractors shall return to provider (RTP) Part A claims. Contractors shall not mail an MSN for these claims.

- Contractors shall return as unprocessable Part B claims. Contractors shall use Reason Code 140 (Patient/Insured health identification number and name do not match). Contractors shall not mail an MSN for these claims.

- For *assigned and* unassigned Part B claims submitted by the beneficiary on the Form CMS-1490S *or Form CMS-1500,* contractors shall *manually return the claim in accordance with Pub.100-04, Chapter 1, Section 80.3.2 A. "Special Considerations."*