CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 220	Date: AUGUST 24, 2007
	Change Request 5550

SUBJECT: Various Medical Review Clarifications

I. SUMMARY OF CHANGES: Various medical review clarifications were made to chapters 1, 3, 7, 11, and the exhibits.

NEW / REVISED MATERIAL
EFFECTIVE DATE: SEPTEMBER 3, 2007
IMPLEMENTATION DATE: SEPTEMBER 3, 2007

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

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	1/1.2.3/Annual MR Strategy
R	3/3.2/Verifying Potential Error and Setting Priorities
R	3/3.4/Overview of Prepayment and Postpayment Review for MR Purposes
R	3/3.4.1.1/Documentation Specifications for Areas Selected for Prepayment or Postpayment MR
R	3/3.4.2/Medical Review Denial Notices
R	3/3.5.1/Automated Prepayment Review
R	3/3.6/Postpayment Review of Claims for MR Purposes
R	3/3.11.1.6/Provider Notification and Feedback
R	7/7.2.8.3/Provider Types and Subtypes
R	11/11.1.4.1/MIP CERT (Activity Code 21901)
R	Exhibits/Table of Contents
N	Exhibits/Exhibit 2 - Reserved for Future Use
R	Exhibits/3.1/Physicians
R	Exhibits/Exhibit 29 - Reserved for Future Use

III. FUNDING:

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

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

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

Attachment - Business Requirements

Pub. 100-08	Transmittal: 220	Date: August 24, 2007	Change Request: 5550

SUBJECT: Various Medical Review Clarifications

EFFECTIVE DATE: September 3, 2007
IMPLEMENTATION DATE: September 3, 2007

I. GENERAL INFORMATION

A. Background: Various medical review changes were made to chapters 1, 3, 7, 11, and the exhibits.

B. Policy: N/A

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	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5550.1	Contractors shall review the CERT findings.	X	X	X	X	X	X					MR PSCs
5550.2	Contractors should use their internal data to verify that the CERT findings are currently problems of sufficient magnitude to be included in their MR strategy	X	X	X	X	X	X					MR PSCs
5550.3	The PSC shall include logistics of referrals to POE within the AC or MAC in the JOA.											MR PSCs
5550.4	PSC contractors shall report cost and workload in the CMS ART System											MR PSCs
5550.5	Contractors shall have the medical review and provider outreach and education units consult to ensure that duplicate efforts are not being undertaken to resolve identified problems.	X	X	X	X	X	X					MR PSCs
5550.6	Contractors shall initiate appropriate corrective actions when errors are verified.	X	X	X	X	X	X					MR PSCs
5550.7	Contractors shall focus administrative resources to achieve the greatest dollars returned to the Medicare program for resources used.	X	X	X	X	X	X					MR PSCs
5550.8	Contractors should focus where the services billed have significant potential to be noncovered, incorrectly coded, or misrepresented.	X	X	X	X	X	X					MR PSCs
5550.9	Contractors shall have in place a program of innovative, systematic, and ongoing analysis of claims and other relevant data to focus intervention	X	X	X	X	X	X					MR PSCs

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A / B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	efforts on the most significant errors											
5550.10	Contractors shall have the opportunity to make a determination to either affirm payment of a claim or deny payment and assess an overpayment after performing postpayment review.	X	X	X	X	X	X					MR PSCs
5550.11	Contractors shall have MR edits that are coded system logic that either automatically pays all or part of a claim, automatically denies all or part of a claim, or suspends all or part of a claim so that a trained clinician can review the claim.	X	X	X	X	X	X					MR PSCs
5550.12	Contractors' non-automated review work resulting from MR edits shall: 1) involve activities defined under the MIP Section 1893(b)(1) of the Act; 2) be articulated in the contractor's MR strategy; and 3) be designed in such a way as to reduce the CERT error rate.	X	X	X	X	X	X					MR PSCs
5550.13	Contractors shall charge to the appropriate Program Management activity cost center activities from edits that results in work other than that defined in 1893(b)(1) of the Act.	X	X	X	X	X	X					MR PSCs
5550.14	Contractors shall accept alternative signature methods on medical record documentation for medical review purposes, except Hospice certification of terminal illness.	X	X	X	X	X	X					MR PSCs
5550.15	Contractor's clear policy that will be used as the basis for frequency denials shall contain utilization guidelines that the contractor considers acceptable for coverage.	X	X	X	X	X	X					MR PSCs
5550.16	Contactors should automatically deny a service without the review of the claim when medically unbelievable service(s) exist.	X	X	X	X	X	X					MR PSCs
5550.17	Contractors shall adhere in all cases to reopening rules when conducting a postpayment review.	X	X	X	X	X	X					MR PSCs
5550.18	Contractors should perform postpay review and reopen claims for high error rates and /or potential overutilization identified through data analysis.	X	X	X	X	X	X					MR PSCs
5550.19	Contractors should provide notification and feedback to providers through written communication and may follow up by telephone.	X	X	X	X	X	X					MR PSCs
5550.20	Contractors shall provide written notification at least every 6 months to providers that remain on medical review beyond 6 months or until they are referred to BI or have evidence that the problem is corrected.	X	X	X	X	X	X					MR PSCs

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5550.21	Contractor's shall not make payment for unauthorized services outside the Medicare Advantage plan.	X	X	X	X	X	X					MR PSCs
5550.22	Contractors shall include, as members of their CAC, Medicare Advantage organizations.	X	X	X	X	X	X					MR PSCs

III. PROVIDER EDUCATION TABLE

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

IV. SUPPORTING INFORMATION

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

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Debbie.skinner@cms.hhs.gov

Post-Implementation Contact(s): Debbie.skinner@cms.hhs.gov

VI. FUNDING

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

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

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

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

1.2.3 - **Annual MR** Strategy

(Rev.220, Issued: 08-24-07, Effective: 09-03-07, Implementation: 09-03-07)

Each fiscal year, the contractors shall develop and document a unique annual MR Strategy within their jurisdiction. This strategy must be consistent with the goal of reducing the claims payment error rate.

The MR strategy shall detail identified MR issues, activities, projected goals, and the evaluation of activities and goals. It must be a fluid document that is revised, as targeted issues are successfully resolved, and other issues take their place. The initial strategy submitted at the beginning of the fiscal year shall be based on the strategy from the current fiscal year and updated and expanded upon as necessary.

The contractor shall analyze data from a variety of sources in the initial step in updating the MR strategy. The contractor shall use their CERT findings as the primary source of data to base further data analysis in identifying program vulnerabilities. *CERT is only a pointer and cannot be relied upon as a single source of information. Contractors should use their internal data to verify that the CERT findings are (or are not) currently problems of sufficient magnitude to be included in their MR strategy in the appropriate priority. Other problems identified from other sources may be of higher priority, but contractors must review the CERT findings in terms of their own data and MR activities.* Other data sources can include, but are not limited to, information gathered from other operational areas, such as appeals and inquiries, that interact with MR and *Provider Outreach and Education* POE.

After information and data is gathered and analyzed, the contractor shall develop and prioritize a problem list. A problem list is a list of the program vulnerabilities that threaten the Medicare Trust Fund that can be addressed through MR activities. The contractor shall consider resources and the scope of each identified medical review issue, when prioritizing their problem list. In addition, the contractor shall identify and address, in the problem list, work that is currently being performed and problems that will carry over to the following fiscal year. Once a problem list is created, the contractor shall develop MR interventions using the PCA process (IOM Pub.. 100-8, chapter 3, section 14) to address each problem.

The methods and resources used for MR interventions depend on the scope and severity of the problems identified and the action needed to successfully address the problems. For example, if initial MR actions such as an MR notification letter to the provider and placement on prepayment review are insufficient to improve the provider's billing accuracy, a priority referral to POE for potential intervention may be necessary. Alternately, if on initial probe, a medium or high priority problem is identified, MR may determine that the initial issuance of probe result letter is insufficient, and a priority referral to POE, and/or more intensive medical review corrective actions may be required. A priority referral is an indication to the POE department that this is a problem which MR has determined will likely require further educational intervention. If, through communication with POE, it is determined that MR intervention and POE educational

efforts have not effectively resolved the problem, a referral to the PSC BI unit may be indicated.

In addition, all claims reviewed by medical review shall be identified by MR data analysis and addressed as a prioritized problem in the MR strategy and reflected in the SAR. If resources allow, an MR nurse may be shared with another functional area, such as claims processing, as long as only the percentage of the nurses time spent on MR activities is identified in the strategy and accounted for in the appropriate functional area. For example, if MR agrees to share 0.5 of an FTE with claims processing to assist with the pricing of NOC claims, this 0.5 FTE shall be accounted for in claims processing.

The contractor shall develop multiple tools to effectively address identified problems for the local Medicare providers. The MR strategy shall include achievable goals and evaluation methods that test the effectiveness and efficiency of activities designed to resolve targeted medical review problems. These evaluation methods will be dependent upon effective communication between the MR and POE departments. MR shall work with POE to develop an effective system of communication regarding the disposition of problems referred to POE. Within MR, a system shall be used to track referrals to POE, follow-up communication with POE, and MR interventions used to address identified problems. The PSC shall include what information is required in the referrals to POE within the AC or MAC JOA.

As problems are addressed within MR or referred to POE, the MR department shall incorporate processes for follow-up that ensure appropriate resolution of the issue. If aberrancies continue, the contractor shall use the information gathered through communication with POE to determine a more progressive course of action, such as increase in prepay MR, priority referral to POE, or referral to BI in cases of suspected fraud. Effective tracking of MR and POE efforts to resolve identified problems is integral to development of any case referred for potential investigation by the PSC (See PIM, chapter 4, section 4.3). As issues are successfully resolved, the contractor shall continue to address other program vulnerabilities identified on the problem list.

The MR strategy shall include a section that describes the process used to monitor spending in each CAFM II Activity Code. The process shall ensure that spending is consistent with the allocated budget and include a process to revise or amend the plan when spending is over or under the budget allocation. In addition, the strategy shall describe how workload for each CAFM II Activity Code is accurately and consistently reported. The workload reporting process shall also assure the proper allocation of employee hours required for each activity. Program safeguard contractors (PSC) shall not report cost and workload using the CAFM II system. Instead, the contractor shall report cost and workload in the CMS analysis, reporting, and tracking *(ART) system.*

In each element of the MR strategy, the contractor shall incorporate quality assurance activities as described below. Quality assurance activities ensure that each element is being performed consistently and accurately throughout the contractor's MR program. In addition, the contractor shall have in place procedures for continuous quality

improvement. Quality Improvement builds on quality assurance in that it allows the contractor to analyze the outcomes from their program and continually improve the effectiveness of their processes.

In order to assist contractors in developing their strategies, the CMS has developed the following generic template that can be used to help guide contractor planning and ensure that all activities and expected outcomes are reported. Examples of actions which might be listed in the intervention list include, but are not limited to service-specific probes, notification letters, POE priority referrals, and automated denials based on LCDs**.**

Figure 1

FY 200_ Medicare Medical Review Strategy

Contractor Name:
Contractor Number:
Contractor MR site location(s):

Data Analysis Plan:
Prioritized Problems: **(1)**
(2)
(3)
Intervention Plan: **(1)**
(2)
(3)
Follow up Plan: **(1)**
(2)
(3)

Program Management:

- **Workload management process**
- **Cost allocation management process**
- **Staffing & Resource management process**
- **CMS Mandates**
- **PSC support**

Budget and Workload Chart:

Staffing Chart:

List all the problems identified and prioritize them. The contractor shall describe the method and criteria used to prioritize the problem list. The contractor should consider using scope of problem and resources available as criteria to prioritize the list. The list should be long while the MR strategy may only address the first few initially. When developing their prioritized list, the contractor shall consider their resources and other operational areas of the contractor with similar goals. The MR strategy is a fluid

document and shall be continuously reviewed and adjusted as problems are resolved and new problems take are addressed.

Quality Assurance:

The contractor shall list the data and the metrics used to determine and verify each identified problem. That is, each identified problem should have an explanation of data and other information used to support the decision to include the problem and assign its priority. In addition, the quality assurance process shall ensure that MR *consults with* POE to *ensure that duplicate efforts are not being undertaken* or consistently being overturned on appeal. Furthermore, an effective quality assurance process shall include periodic meetings with other operational areas, including POE.

3.2 – Verifying Potential Error and Setting Priorities

(Rev.220, Issued: 08-24-07, Effective: 09-03-07, Implementation: 09-03-07)

Understanding the characteristics of the service area of the provider is a key element of claim data analysis. The areas selected for review by the contractor (e.g., providers, services) must be deemed high priority and contractors must be able to document the rationale for selection. Using claims data, contractors shall determine the degree to which a potential error is widespread and decide if the potential error meets the deviation indicators established. When services and/or providers appear outside of norms, the contractor must verify that the potential error represents an unacceptable practice. Further investigate the provider(s) identified as causing the potential error.

Some examples of possible legitimate explanations for potential error are listed below. This is not an all-inclusive list.

- The provider may be associated with a medical school, research center, or may be a highly specialized facility; and
- The community may have special characteristics such as economic level or a concentration of a specific age group that leads to the aberrancy;

A. Error Validation *(Probe)* Review

If no legitimate explanation exists for the potential error, the contractor should verify the cause of a potential error. The contractor shall not suspend large volumes of claims for review or use 100% prepayment review. Instead, the contractor shall select a sample of cases which is representative of the universe where the problem is occurring. The contractor shall request appropriate medical documentation and review cases for coverage and correct coding. MR staff should not be reviewing claims for compliance with other Medicare rules (i.e., claims processing, conditions of participation, etc.). Error validation reviews may be conducted on a prepayment or postpayment basis.

Where errors are verified, the contractor shall initiate appropriate corrective actions found in PIM, chapter 3, §§5, 6, and *8 through 13*.

Where no corrective action is taken, the contractor must document findings and explanations for not pursuing the problem. If no problems are found, the contractor shall discontinue the review. Do not wait until the end of the quarterly reporting period to end the review process.

In all situations where errors have been verified, the MR unit must notify the provider (written or verbal) that the particular practice or behavior is inappropriate and should not continue.

Error validation *(probe)* reviews require the examination of the provider's medical documentation but do not require use of statistical sampling for overpayment estimation

methodologies. It does not allow projection of overpayments to the universe of claims reviewed. In this type of review, contractors collect overpayments only on claims that are actually reviewed, determined to be non-covered or incorrectly coded, and the provider is liable or at fault for the overpayment.

It may be used to determine:

- The extent of a problem across multiple providers, or
- Whether an individual provider has a problem.

Contractors shall select providers for error validation *(probe)* reviews in, at a minimum, the following instances:

- The contractor has identified questionable billing practices, (i.e., noncovered or incorrectly coded services) through data analysis.
- Alerts from other intermediaries, carriers, QIOs, intermediary payment staff, or other internal components are received that warrant such review;
- Complaints.

Contractors must document their reasons for selecting the provider for the error validation *(probe)* review. In all cases, they must clearly document the issues cited and the applicable law or their Pub.lished national coverage policies or local coverage determinations, if applicable.

B. Setting Priorities

Contractors shall focus administrative resources to achieve the greatest dollars returned to the Medicare program for resources used. This requires establishing a priority setting process to assure MR focuses on areas with the greatest potential for fraud and abuse. Fraud and abuse may be demonstrated by high dollar payments, high volume of services, dramatic changes, or significant risk for negative impact on beneficiaries (e.g., low volume but unnecessary surgery).

Efforts to stem errors shall be targeted to those areas which pose the greatest financial risk to the Medicare program and which represent the best investment of resources. Contractors should focus where the services billed have significant potential to be noncovered, incorrectly coded, or misrepresented. Target areas may be selected because of:

- *High volume;*
- *High cost;*
- *Dramatic change;*

- *Adverse impact on beneficiaries; and/or*

- *Problems which, if not addressed, may escalate.*

Contractors have the authority to review any claim at any time, however, the claims volume of the Medicare program prohibits review of every claim. Resources dictate that in attempting to make only correct payments, contractors make deliberate decisions on the best uses of limited resources to maximize returns. For example, contractors may decide not to review claims for certain services or providers for extended periods of time. Medical review staff may decide to focus review on problem areas that demonstrate significant risk to the Medicare program as a result of inappropriate or potentially inappropriate payments. Contractors shall have in place a program of innovative, systematic, and ongoing analysis of claims and other relevant data to focus intervention efforts on the most significant errors.

3.4 - Overview of Prepayment and Postpayment Review for MR Purposes

(Rev.220, Issued: 08-24-07, Effective: 09-03-07, Implementation: 09-03-07)

The instructions listed in this section (section 3.4) apply only to reviews conducted for MR purposes unless otherwise noted. When MR staff are performing BI-directed prepay or postpay claims review, the MR staff should seek direction from the BI staff. For example, if the provider calls the MR staff and requests feedback on the review results pursuant to the requirements for progressive corrective action, the MR staff should seek guidance from the BI unit.

When MR departments make referrals to POE, they shall maintain communication with POE regarding educational interventions completed and must continue to deny non-covered and incorrectly coded services even while provider education is occurring.

Prepayment MR of claims requires that a benefit category review, statutory exclusion review, reasonable and necessary review, and/or coding review be made BEFORE claim payment. Prepayment MR of claims always results in an "initial determination." See Pub.. 100-04, chapter 29, section 30.3, for a complete definition of "initial determination."

Postpayment MR of claims requires that a benefit category review, statutory exclusion review, reasonable and necessary review, and/or coding review be made AFTER claim payment. These types of review allow the contractor the opportunity to make a determination to either *affirm payment of* a claim (in full or in part), *or* deny payment *and* assess an overpayment. Postpayment MR of claims may result in no change to the initial determination or may result in a "revised determination." See 42 CFR 405.841 and 42 CFR 405.750 for a complete definition of "revised determination."

When initiating prepay or postpay review (provider specific or service-specific), contractors must notify providers of the following:

- That the provider has been selected for review and the specific reason for such selection. If the basis for selection is comparative data, contractors must provide comparative data on how the provider varies significantly from other providers in the same specialty payment area or locality. Graphic presentations may help to communicate the perceived problem more clearly;

- Whether the review will occur on a prepayment or postpayment basis;

- If postpayment, the list of claims that require medical records; and

- The OMB Paperwork Reduction Act collection number, which is 0938-0969. This number needs to be on every additional documentation request (ADR) or any other type of written request for additional documentation for medical review. It can be in the

header, footer or body of the document. We suggest the information read “OMB #: 0938-0969” or “OMB Control #: 0938-0969.”
This notice must be in writing and may be issued separately or in the same letter that lists the additional documentation that is being requested. Contractors may (but are not required to) make this notification via certified letter with return receipt requested. In addition, the contractor may include information on its Web site explaining that service-specific review will be occurring and the rationale for conducting such review.

The MR edits are coded system logic that either automatically pays all or part of a claim, automatically denies all or part of a claim, or suspends all or part of a claim so that a trained clinician can review the claim and associated documentation (including documentation requested after the claim is submitted) in order to make a determination under Section 1862(a)(1)(A) of the Social Security Act (the Act). Namely: is the claim medically reasonable and necessary in order to diagnose or treat an injury or improve the functioning of a malformed body member. All non-automated review work resulting from MR edits shall: 1) involve activities defined under the Medicare Integrity Program (MIP) at Section 1893(b)(1) of the Act; 2) be articulated in the contractor's medical review strategy; and 3) be designed in such a way as to reduce the contractor's Comprehensive Error Rate Testing (CERT) error rate or prevent the contractor's CERT error rate from increasing.

Edits which suspend a claim for manual review to check for completeness of claims, conditions of participation, adherence to prescribing standards, coding, pricing or other non-clinical issues are not medical review edits. These activities are not defined under 1893(b)(1) of the Act and cannot be funded by MIP. Therefore, edits which result in work other than that defined in 1893(b)(1), shall be charged to the appropriate Program Management activity cost center.

3.4.1.1 - Documentation Specifications for Areas Selected for Prepayment or Postpayment MR

(Rev.220, Issued: 08-24-07, Effective: 09-03-07, Implementation: 09-03-07)

The contractor may use any information they deem necessary to make a prepayment or postpayment claim review determination. This includes reviewing any documentation submitted with the claim as well as soliciting documentation from the provider or other entity when the contractor deems it necessary and in accordance with PIM, chapter 3, §3.4.1.2.

A. Review of Documentation Submitted with the Claim

If a claim is targeted based on data for prepayment or postpayment medical review (including automated, routine, or complex) contractors may review unsolicited supporting documentation accompanying the claim, but are not required to do so.

There are two exceptions to this rule. Contractors may deny without reviewing attached or simultaneously submitted documentation (1) when clear policy serves as the basis for denial, and (2) in instances of medical impossibility (see PIM, chapter 3, §3.5.1).

NOTE: The term "clear policy" means a statute, regulation, NCD, coverage provision in an interpretive manual, or LCD that specifies the circumstances under which a service will always be considered non-covered or incorrectly coded. Clear policy that will be used as the basis for frequency denials must contain utilization guidelines that the contractor considers acceptable for coverage.

If a contractor chooses to allow supporting paper documentation to be submitted with the claim for medical review purposes the contractor shall inform providers in their jurisdiction of that fact (see PIM, chapter 3, §3.5).

B. Signature Requirements

Medicare requires a legible identifier for services provided/ordered. The method used *may be* hand written *or an* electronic signature to sign an order or other medical record documentation for medical review purposes. *Therefore,* a signature in some form, needs to be present. Do not deny a claim on the sole basis of type of signature submitted.

Noted Exception: Signature(s) of the physician(s) must be written on the certifications of terminal illness for hospice.

Providers using alternative signature methods *(electronic systems)* should recognize that there is a potential for misuse or abuse with alternate signature methods. For example, *providers need a system and software products which are protected against modification, etc., and should apply administrative procedures which are adequate and correspond to recognized standards and laws.* The individual whose name is on the alternate signature method bears the responsibility for the authenticity of the information being attested to. Physicians should check with their attorneys and malpractice insurers in regard to the use of alternative signature methods.

All State licensure and State practice regulations continue to apply. Where State law is more restrictive than Medicare, the contractor needs to apply the State law standard. The signature requirements described here do not assure compliance with Medicare conditions of participation.

Note that this instruction *does not supersede the prohibition* for Certificates of Medical Necessity (CMNs) and DME MAC Information Forms (DIFs). CMNs and DIFs are forms used to determine if the medical necessity and applicable coverage criteria for Durable Medical Equipment, Prosthetic, and Orthotic Supplies (DMEPOS) have been met.

C. Review of Documentation Solicited After Claim Receipt

The process whereby a contractor requests additional documentation after claim receipt is known as "development." Providers selected for review are responsible for submitting medical records requested of them by the contractor within established timeframes. Development requirements are listed below in section 3.4.2.1.

D. Requirements That Certain Tests Must Be Ordered By The Treating Physician

Effective November 25, 2002, 42 CFR 410.32(a) requires that when billed to any contractor, all diagnostic x-ray services, diagnostic laboratory services, and other diagnostic services must be ordered by the physician who is treating the beneficiary for a specific medical problem and who uses the results in the management of the beneficiary's specific medical problem.

E. Diagnosis Requirements

Section 1833(e) of the Act provides that no payment may be made "under this part unless there has been furnished such information as may be necessary in order to determine the amounts due such provider or other person . . ."Contractors may require information, in accordance with the requirements below whenever they deem necessary to make a determination listed in section 3.4.1 and thus to determine appropriate payment.
Some provider types are required to submit diagnosis codes on all claims while other provider types are required to submit diagnosis codes only if such information is required by an *LCD*.

- Claims Submitted by Physicians or **§1842(b)(18)(C) of the Act** Practitioners Must Contain Diagnosis Codes.

Section 1842 (p)(1) of the Act states that each claim submitted by a physician or §1842(b)(18)(C) of the Act practitioner "shall include the appropriate diagnosis code (or codes)…". For services from physicians and §1842(b)(18)(C) of the Act practitioners submitted with an ICD-9 code that is missing, invalid, or truncated, contractors must return the billed service to the provider as unprocessable in accordance with MCM §3005.4(p) or MIM §3605.3.

- Claims Submitted By All Other Provider Types Must Contain Diagnosis Codes If Such Codes Are Required By An *LCD* (effective 7/1/02).

In order to address potential abuse or overutilization, contractors can require that ICD-9 diagnosis codes be submitted with each claim for the targeted service. This information is used in determining whether the services are covered and correctly coded. Effective April 1, 2002, contractors may require ICD-9 diagnosis codes to be submitted by all non-physician billers with every claim for a targeted service only if such a requirement appears in an *LCD* for that service. Contractors must educate providers about this requirement beginning no later than January 1, 2002. This outreach should occur via Web site bulletin articles, etc.

For individual non-physician providers who are identified due to unusual billing practices, fraud referrals, etc., contractors may also require ICD-9 diagnosis codes to support the medical necessity of all or some claims submitted by the targeted entities, even if no *LCD* exists requiring such codes.
For services submitted with an ICD-9 diagnosis code that is missing, incorrect or truncated as indicated above, contractors must return the billed service to the provider as unprocessable.

F. Requirements for Lab Claims

The American Medical Association's (AMA) 1998 edition of the Current Procedural Terminology (CPT) established three new and one revised Organ or Disease Oriented laboratory panels. Since these panels are composed of clinically relevant groupings of automated multichannel tests there is a general presumption of medical necessity. If there is data or reason to suspect abuse of the new panel codes, contractors may review these claims. Should contractors determine the need to develop a *LCD* for laboratory panel codes, develop these policies at the panel code level. In some instances of perceived abuse of the new panel codes, you may review the panel and deny component tests on a case-by-case basis or evaluate the need for the component level test.

3.4.2 –Medical Review Denial Notices

(Rev.220, Issued: 08-24-07, Effective: 09-03-07, Implementation: 09-03-07)

Contractors must deny claims, in full or in part, under the circumstances listed below. Contractors do not have the option to "Return to Provider" or reject claims under these circumstances. Contractors must deny the claim in full or in part. See CMS Pub.. IOM 100-04, chapter 30, §20.1 for further information on partials denials (known as "down coding").

A. Denial Reasons Used for Reviews Conducted for MR or BI Purposes

Contractors must deny payment on claims either partially (e.g., by down coding, or denying one line item on a multi-line claim) or in full and provide the specific reason for the denial whenever there is evidence that a service:

- Does not meet the Benefit Category requirements described in Title XVIII of the Act and national coverage determination, coverage provision in interpretive manual;

- Is statutorily excluded by other than §1862(a)(1) of the Act;

- Is not reasonable and necessary as defined under §1862(a)(1) of the Act. (Contractors shall use this denial reason for all non-responses to ADRs.); and

- Was not billed in compliance with the national and local coding requirements; or

- Does not meet reasonable and necessary criteria specified in an LCD.

Contractors must give the specific reason for denial. Repeating one of the above bullets is not a specific reason. An exception to this instruction may occur when a demand bill (condition code 20) is submitted with an administrative error, such as when the beneficiary has not selected the checkbox indicating he or she wants Medicare to be billed on the HHABN (see CMS Pub.. IOM 100-08, chapter 11, §11.1.3.4 for instructions regarding appropriate intermediary processes when this situation occurs). In most cases, the contractor shall RTP such claims submitted in error, except in the case of dual-eligible beneficiaries where there is a state-specific policy, as described in IOM 100-04, chapter 30, §60.5 A.

B. Denial Reasons Used for Reviews Conducted for BI Purposes

Contractors must deny payment on claims either partially (e.g., by down coding or denying one line item on a multi-line claim) or in full whenever there is evidence that a service:

- Was not rendered (or was not rendered as billed);

- Was furnished in violation of the self referral prohibition; or

- Was furnished, ordered or prescribed on or after the effective date of exclusion by a provider excluded from the Medicare program and that provider does not meet the exceptions identified below in PIM chapter 4, §4.*19*.2.6.

Contractors must deny payment whenever there is evidence that an item or service was not furnished, or not furnished as billed even while developing the case for referral to OIG or if the case has been accepted by the OIG. In cases where there is apparent fraud, but the case has been refused by law enforcement, contractors deny the claim(s) and collect the overpayment where there is fraud- - after notifying law enforcement. It is necessary to document each denial thoroughly to sustain denials in the appeals process. Intermediaries must make adjustments in cost reports, as appropriate.

C. Denial Notices

If a claim is denied, in full or in part, the contractor must notify the beneficiary and/or the provider. The contractor shall include limitation of liability and appeals information. Notification can occur via Medicare Summary Notice (MSN) and Remittance Advice.

Beneficiary Notices

Contractors are required to give notice to Medicare beneficiaries when claims are denied in part or in whole based on application of an LCD. All denials that result from LCDs must provide the MSN message 15.19 in addition to the current applicable message. Message 15.19 states (Pub.. 100-04, chapter 21):

> "A local medical review policy (LMRP) or local coverage determination (LCD) was used when we made this decision. An LMRP/LCD provides a guide to assist in determining whether a particular item or service is covered by Medicare. A copy of this policy is available from your local intermediary or carrier by calling the number in the customer service information box on page one. You can compare the facts in your case to the guidelines set out in the LMRP/LCD to see whether additional information from your physician would change our decision."

You shall make these messages available in Spanish where appropriate. The 15.19 portion of the MSN message states:

> 15.19 - Una Política Local de Revisión Médica (LMRP, por sus siglas en inglés) o una Determinación de Cobertura Local (LCD, por sus siglas en inglés) fue utilizada cuando se tomó esta decisión. La Política Local de Revisión Médica y la Determinación de Cobertura Local proveen una guía que ayuda a determinar si un artículo o servicio en particular está cubierto por Medicare. Una copia de esta política está disponible en su intermediario o su empresa de seguros Medicare local al llamar al número que aparece en la sección de Servicios al Cliente en la página uno. Usted puede comparar los datos de su caso con las reglas establecidas en la Política Local de Revisión Médica y en la Determinación de Cobertura Local para ver si obteniendo información adicional de su médico pudiera cambiar nuestra decisión.

Use the above message in every instance of a prepayment denial where an LCD was used in reviewing the claim. Use this message, and message 15.20 (now for FISS FI's, and when 15.20 is fully implemented for contractors on the MCS/VMS systems) on both full and partial denials, whether the denial was made following automated, routine, or complex review. Do not use this message on denials not involving LCDs. For claims reviewed on a postpayment basis, use the above message if sending the beneficiary a new MSN. If sending a letter, include the language exactly as contained in the MSN message above.

Message 15.20 currently states "The following policies [insert LCD ID #(s) and NCD #(s)] were used when we made this decision."(Pub.. 100-04, chapter 21). 15.19 must continue to be used in conjunction with the MSN message 15.20, where 15.19 is applicable. Contractors may combine these messages if necessary, but 15.19 must not be deleted.

Provider Notices

Prepay Denial Messages

Because the amount of space is limited, contractors need only provide high-level information to providers when informing them of a prepayment denial via a remittance advice. In other words, the shared standard system remittance advice messages are sufficient notices to the provider. However, for routine and complex review, the

contractor must retain more detailed information in an accessible location so that upon written or verbal request from the provider, the contractor can explain the specific reason the service was considered non-covered or not correctly coded.

Post Pay Denial Messages

When notifying providers of the results of post pay medical review determinations, the contractor must explain the specific reason each service was considered non-covered or not correctly coded.

Indicate in the Denial Notice Whether Records Were Reviewed

Effective March 1, 2002, for claims where the contractor has sent an ADR letter and no timely response was received, contractors must make a §1862(a)(1) of the Act denial (except for ambulance claims where the denial may be based on §1861(s)(7) or §1862(a)(1)(A) of the Act depending upon the reason for the requested information) and indicate in the provider denial notice, using remittance advice code N102, that the denial was made without reviewing the medical record because the requested records were not received or were not received timely. This information will be useful to the provider in deciding whether to appeal the decision.

For claims where the contractor makes a denial following complex review, contractors may, at their discretion, indicate in the denial notice, using remittance advice code N109 that the denial was made after review of medical records. This includes those claims where the provider submits medical records at the time of claim submission and the contractor selects that claim for review.

D. Audit Trail

For reporting purposes, contractors need to differentiate automated, routine and complex prepayment review of claims. Contractor systems must maintain the outcome (e.g., audit trail) of prepayment decisions such as approved, denied, or partially denied. When downcoding, contractors must retain a record of the HCPCS codes and modifiers that appeared on the original claim as submitted.

E. Distinguishing Between Benefit Category, Statutory Exclusion and Reasonable and Necessary Denials

Contractors must be very careful in choosing which denial type to use since beneficiaries' liability varies based on denial type. Benefit category denials take precedence over statutory exclusion and reasonable and necessary denials. Statutory exclusion denials take precedence over reasonable and necessary denials. Contractors should use HCFA Ruling 95-1 and the guidelines listed below in selecting the appropriate denial reason.

- If the contractor requests additional documentation from the provider or other entity (in accordance with PIM chapter 3, section 4.1.2.) for any MR reason (benefit category, statutory exclusion, reasonable/necessary, or coding), and the information is not

received within 45 days, the contractor should issue a reasonable and necessary denial, in full or in part.

- If the contractor requests additional documentation because compliance with a benefit category requirement is questioned and the contractor receives the additional documentation, but the evidence of the benefit category requirement is missing, the contractor should issue a benefit category denial.

- If the contractor requests additional documentation because compliance with a benefit category requirement is questioned and the contractor receives the additional documentation, which shows evidence that, the benefit category requirement is present but is defective, the contractor should issue a reasonable and necessary denial.

EXAMPLE: A contractor is conducting a review of partial hospitalization (PH) services on a provider who has a problem with failing to comply with the benefit category requirement that there be a signed certification in the medical record. In the first medical record, the contractor finds that there is no signed certification present in the medical record. The contractor must deny all PH services for this beneficiary under §1835(a)(2)(F) of the Act (a benefit category denial). However, in the second medical record, the contractor determines that a signed certification is present in the medical record, but the documentation does not support the physician's certification, the services must be denied under §1862(a)(1)(A) of the Act (a reasonable and necessary denial) because the certification is present but defective.

If a contractor performs routine review on a surgical procedure and determines that the procedure was cosmetic surgery and was not reasonable and necessary, the denial reason would be that the service is statutorily excluded since statutory exclusion denials take precedence over reasonable and necessary denials.

3.5.1 - Automated Prepayment Review

(Rev.220, Issued: 08-24-07, Effective: 09-03-07, Implementation: 09-03-07)

When prepayment review is automated, decisions are made at the system level, using available electronic information, without the intervention of contractor personnel. When appropriately implemented, automated review increases efficiency and consistency of decisions. Contractors must implement automated prepayment review whenever appropriate.

Automated review must:

Have clear policy that serves as the basis for denial; or

Be based on a medically unbelievable service(s); or

Occur when no timely response is received in response to an ADR letter.

When a clear policy (see PIM Chapter 3, Section 3.4.1.1) exists or in the case of a medically unbelievable service(s), contractors may automatically deny the services without stopping the claim for routine or complex review, even if documentation is attached. Reviewers must still make a §1879 of the Act limitation on liability determination, which may require routine review. If additional documentation has been requested for a claim and the information has not been received within 45 days, the denial can be counted as an automated review if there was no human intervention. If human intervention occurs, the denials are counted as routine review.

NOTE: The term "clear policy" means a statute, regulation, NCD, coverage provision in an interpretive manual, or *LCD* specifies the circumstances under which a service will always be considered non-covered or incorrectly coded. *Clear policy that will be used as the basis for frequency denials must contain utilization guidelines that the contractor considers acceptable for coverage.*

3.6 – Postpayment Review of Claims for MR Purposes

(Rev.220, Issued: 08-24-07, Effective: 09-03-07, Implementation: 09-03-07)

The instructions listed in this section (Section 3.6) apply only to reviews conducted for MR purposes unless otherwise noted.

Postpayment claims review occurs when a contractor makes a coverage or coding determination after a claim has been paid. *When a medically unbelievable service(s) exists, contractors may automatically deny the service without the review of the claim.* This section describes the requirements that contractors must follow when conducting postpayment claims review for MR purposes. Contractors who are reviewing claim*s* on a postpayment basis for potential fraud case development purposes are not required to follow these requirements.

A. Major Steps

There are nine major steps in the postpayment review process:

Step 1: Selecting the Cases for Review (see PIM Chapter 3, Section 3.6.1)

Step 2: Deciding the Location of the Review (See PIM Chapter 3, Section 3.6.2)

Step 3: Re-Adjudicating the Claims (See PIM Chapter 3, Section 3.6.3)

Step 4: Estimating the Over/Underpayment (See PIM Chapter 3, Section 3.6.4)

Step 5: Notification of Review Results (See PIM Chapter 3, Section 3.6.5)

Step 6: Considering/Responding to a Provider's Rebuttal (See PIM Chapter 3, Section 3.6.6)

Step 7: Recovering the Overpayment (See PIM Chapter 3, Section 3.6.7)

Step 8: Evaluating Postpay*ment* Review and Next Steps (See PIM Chapter 3, Section 3.6.8)

Step 9: Maintaining Files (See PIM Chapter 3, Section 3.6.9)

If at any point in these steps a contractor detects potential fraud, the contractor should not take any further steps in the process but should follow the instructions in section 3.6.8.

B. Adherence to Reopening Rules

When conducting a postpayment review, contractors shall adhere in all cases to reopening rules. (See 42CFR405.750; 20 CFR404.988(b) and 404.989.) A high error rate and/or potential overutilization identified through data analysis are reasons to perform postpay review and represents good cause to reopen claims for that purpose in accordance with 42CFR405.750(b)(2).

3.11.1.6 – Provider Notification and Feedback

(Rev.220, Issued: 08-24-07, Effective: 09-03-07, Implementation: 09-03-07)

Provider notification and feedback is an essential part of solving problems.

Provider notification and feedback means direct *communication* between the contractor and the provider through *written communication and may follow up by* telephone as a result of or directly related to a specific claim or group of claims reviewed on probe or complex medical review. The overall goal of providing notification and feedback is to ensure proper billing practices so that claims will be submitted and paid correctly. Remove providers from medical review as soon as possible when they demonstrate compliance with Medicare billing requirements, based on follow-up data analysis conducted by the MR department.

Contractors shall send written notification to all providers when they are placed on medical review and removed from medical review. We recognize that some providers may remain on medical review for long periods of time, despite interventions and use of the PCA concepts. In the case of "extended medical review*", meaning the provider that remains on medical review beyond 6 months or until they are referred to BI or have evidence that the problem or utilization (behavior) is corrected*, provide written notification at least every 6 months. Notification letters must be clear and concise and must include at least the following information: the reasons for medical review; previous review findings (if applicable); planned medical review (level of review and duration), potential for continuation of or increase in medical review levels (if identified problems continue, additional problems are identified, etc.); description of the specific actions the provider must take to resolve the problems identified in the medical review process.

When appropriate, an offer to provide individualized education may be included in the notification letter, along with contact information for POE, the department which will be responsible for further educating on the topic. When inquiries are received in response to a provider notification or feedback letter, ONLY responses to those inquiries directly related to a specific claim or group of claims reviewed on probe or targeted medical review should be charged to Medical Review, in the appropriate CAFM activity code for the type of review performed.

<u>Comparative Billing Reports</u>

Contractors can develop and issue comparative billing reports in 3 situations: (1) Included in provider-specific notification and feedback letter, (2) provider-specific reports for individuals who have requested a report, and (3) service-specific reports.

1) Provider-specific reports.

To address potential over-utilization, contractors may give provider-specific comparative billing reports to those providers that demonstrate the highest utilization for the services they bill, to be included in the feedback and notification letters issued as a result of probe

or Targeted Medical Review. These reports must provide comparative data on how the provider varies from other providers in the same specialty payment area or locality. Graphic presentations may help to communicate the provider's billing pattern more clearly. Contractors may NOT charge a fee for providing these reports.

2) Provider-specific or specialty-specific comparative billing reports for requestors.

In order to provide good customer service, contractors may give provider-specific reports to providers or provider associations who request such a report. Contractors may charge a fee for providing these discretionary reports. However, any money collected must be reported as a credit in the applicable CAFM II Activity and accompanied with a rationale for charging the fee. Revenues collected from these discretionary activities must be used only to cover the cost of these activities, and may not be used to supplement other contractor activities. If contractors choose to make such reports available, contractors must describe on their website the mechanism by which a provider or provider association can request such a report and the fee for it.

3) Service-specific comparative billing reports.

When widespread problems are verified, contractors should refer that information to POE for possible website posting. Contractors may NOT charge a fee for posting these reports.

The contractor shall ensure that POE staff have ready access to copies of all MR provider notification and feedback letters so that POE staff will have this information available should a provider contact POE requesting education. If the problem identified by MR is of medium or high priority, a priority referral may also be made to POE, to alert POE staff to the degree of severity and educational need.

7.2.8.3 - Provider Types and Subtypes

(Rev.220, Issued: 08-24-07, Effective: 09-03-07, Implementation: 09-03-07)

Provider Types for Parts A and B
(Use These Codes for Reporting Provider Type)

Provider Type Code	Part Code	Description
000001	B	PHYSICIAN
000002	B	NON-PHYSICIAN
000011	A	HOSPITAL, INPATIENT (INCLUDING PART A)
000012	A	HOSPITAL, (PART B ONLY) OR HOME HEALTH VISITS UNDER PART B
000013	A	HOSPITAL, OUTPATIENT (HHA-A ALSO)
000014	A	HOSPITAL, OTHER (PART B)
000015	A	HOSPITAL, INTERMEDIATE CARE - LEVEL I
000016	A	HOSPITAL, INTERMEDIATE CARE - LEVEL 2
000017	A	HOSPITAL, INTERMEDIATE CARE - LEVEL 3
000018	A	HOSPITAL, SWING BED
000019	A	HOSPITAL, RESERVED FOR NATIONAL ASSIGNMENT
000021	A	SKILLED NURSING FACILITY (SNF), INPATIENT (INCLUDING PART A)
000022	A	SKILLED NURSING FACILITY (SNF), HOSPITAL, (PART B ONLY) OR HOME HEALTH VISITS UNDER PART B
000023	A	SKILLED NURSING FACILITY (SNF), HOSPITAL, OUTPATIENT (HHA-A ALSO)
000024	A	SKILLED NURSING FACILITY (SNF), HOSPITAL, OTHER (PART B)
000025	A	SKILLED NURSING FACILITY (SNF), HOSPITAL, INTERMEDIATE CARE - LEVEL I
000026	A	SKILLED NURSING FACILITY (SNF), HOSPITAL, INTERMEDIATE CARE - LEVEL 2
000027	A	SKILLED NURSING FACILITY (SNF), HOSPITAL, INTERMEDIATE CARE - LEVEL 3
000028	A	SKILLED NURSING FACILITY (SNF), HOSPITAL, SWING BED
000029	A	SKILLED NURSING FACILITY (SNF), HOSPITAL, RESERVED FOR NATIONAL ASSIGNMENT
000031	A	HOME HEALTH ASSOCIATION (HHA), INPATIENT (INCLUDING PART A)
000032	A	HOME HEALTH ASSOCIATION (HHA), HOSPITAL, (PART B ONLY) OR HOME HEALTH VISITS UNDER PART B

Provider Type Code	Part Code	Description
000033	A	HOME HEALTH ASSOCIATION (HHA), HOSPITAL, OUTPATIENT (HHA-A ALSO)
000034	A	HOME HEALTH ASSOCIATION (HHA), HOSPITAL, OTHER (PART B)
000035	A	HOME HEALTH ASSOCIATION (HHA), HOSPITAL, INTERMEDIATE CARE - LEVEL I
000036	A	HOME HEALTH ASSOCIATION (HHA), HOSPITAL, INTERMEDIATE CARE - LEVEL 2
000037	A	HOME HEALTH ASSOCIATION (HHA), HOSPITAL, INTERMEDIATE CARE - LEVEL 3
000038	A	HOME HEALTH ASSOCIATION (HHA), HOSPITAL, SWING BED
000039	A	HOME HEALTH ASSOCIATION (HHA), HOSPITAL, RESERVED FOR NATIONAL ASSIGNMENT
000041	A	CHRISTIAN SCIENCE (CS) HOSPITAL, INPATIENT (INCLUDING PART A)
000042	A	CHRISTIAN SCIENCE (CS) HOSPITAL, (PART B ONLY) OR HOME HEALTH VISITS UNDER PART B
000043	A	CHRISTIAN SCIENCE (CS) HOSPITAL, OUTPATIENT (HHA-A ALSO)
000044	A	CHRISTIAN SCIENCE (CS) HOSPITAL, OTHER (PART B)
000045	A	CHRISTIAN SCIENCE (CS) HOSPITAL, INTERMEDIATE CARE - LEVEL I
000046	A	CHRISTIAN SCIENCE (CS) HOSPITAL, INTERMEDIATE CARE - LEVEL 2
000047	A	CHRISTIAN SCIENCE (CS) HOSPITAL, INTERMEDIATE CARE - LEVEL 3
000048	A	CHRISTIAN SCIENCE (CS) HOSPITAL, SWING BED
000049	A	CHRISTIAN SCIENCE (CS) HOSPITAL, RESERVED FOR NATIONAL ASSIGNMENT
000051	A	CS EXTENDED CARE, INPATIENT (INCLUDING PART A)
000052	A	CS EXTENDED CARE, (PART B ONLY) OR HOME HEALTH VISITS UNDER PART B
000053	A	CS EXTENDED CARE, OUTPATIENT (HHA-A ALSO)
000054	A	CS EXTENDED CARE, OTHER (PART B)
000055	A	CS EXTENDED CARE, INTERMEDIATE CARE - LEVEL I
000056	A	CS EXTENDED CARE, INTERMEDIATE CARE - LEVEL 2
000057	A	CS EXTENDED CARE, INTERMEDIATE CARE - LEVEL 3
000058	A	CS EXTENDED CARE, SWING BED
000059	A	CS EXTENDED CARE, RESERVED FOR NATIONAL

Provider Type Code	Part Code	Description
		ASSIGNMENT
000061	A	INTERMEDIATE CARE, INPATIENT (INCLUDING PART A)
000062	A	INTERMEDIATE CARE, (PART B ONLY) OR HOME HEALTH VISITS UNDER PART B
000063	A	INTERMEDIATE CARE, OUTPATIENT (HHA-A ALSO)
000064	A	INTERMEDIATE CARE, OTHER (PART B)
000065	A	INTERMEDIATE CARE, INTERMEDIATE CARE - LEVEL I
000066	A	INTERMEDIATE CARE, INTERMEDIATE CARE - LEVEL 2
000067	A	INTERMEDIATE CARE, INTERMEDIATE CARE - LEVEL 3
000068	A	INTERMEDIATE CARE, SWING BED
000069	A	INTERMEDIATE CARE, RESERVED FOR NATIONAL ASSIGNMENT
000071	A	CLINIC OR HOSPITAL-BASED RENAL DIALYSIS FACILITY, RURAL HEALTH
000072	A	CLINIC OR HOSPITAL-BASED RENAL DIALYSIS FACILITY, HOSPITAL BASED OR INDEPENDENT RENAL DIALYSIS FACILITY
000073	A	CLINIC OR HOSPITAL-BASED RENAL DIALYSIS FACILITY, INDEPENDENT PROVIDER BASED FEDERALLY QUALIFIED HEALTH CENTER (EFF 10/91)
000074	A	CLINIC OR HOSPITAL-BASED RENAL DIALYSIS FACILITY, OTHER REHABILITATION FACILITY (ORF) ONLY(EFF 4/97)
000075	A	CLINIC OR HOSPITAL-BASED RENAL DIALYSIS FACILITY, COMPREHENSIVE REHABILITATION CENTER (CORF)
000076	A	CLINIC OR HOSPITAL-BASED RENAL DIALYSIS FACILITY, COMMUNITY MENTAL HEALTH CENTER (CMHC) (EFF 4/97)
000077	A	CLINIC OR HOSPITAL-BASED RENAL DIALYSIS FACILITY, RESERVED FOR NATIONAL ASSIGNMENT
000078	A	CLINIC OR HOSPITAL-BASED RENAL DIALYSIS FACILITY, RESERVED FOR NATIONAL ASSIGNMENT
000079	A	CLINIC OR HOSPITAL-BASED RENAL DIALYSIS FACILITY, OTHER
000081	A	SPECIAL FACILITY OR ASC SURGERY, HOSPICE [1500-1799] (NON-HOSPITAL BASED)
000082	A	SPECIAL FACILITY OR ASC SURGERY, HOSPICE [1500-1799] (HOSPITAL BASED)
000083	A	SPECIAL FACILITY OR ASC SURGERY, AMBULATORY SURGICAL CENTER
000084	A	SPECIAL FACILITY OR ASC SURGERY, FREESTANDING

Provider Type Code	Part Code	Description
		BIRTHING CENTER
000085	A	SPECIAL FACILITY OR ASC SURGERY, RURAL PRIMARY CARE HOSPITAL (EFF 10/94)
000086	A	SPECIAL FACILITY OR ASC SURGERY, RESERVED FOR NATIONAL USE
000087	A	SPECIAL FACILITY OR ASC SURGERY, RESERVED FOR NATIONAL USE
000088	A	SPECIAL FACILITY OR ASC SURGERY, RESERVED FOR NATIONAL USE
000089	A	SPECIAL FACILITY OR ASC SURGERY, OTHER
000091	A	RESERVED, INPATIENT (INCLUDING PART A)
000092	A	RESERVED, (PART B ONLY) OR HOME HEALTH VISITS UNDER PART B
000093	A	RESERVED, OUTPATIENT (HHA-A ALSO)
000094	A	RESERVED, OTHER (PART B)
000095	A	RESERVED, INTERMEDIATE CARE - LEVEL I
000096	A	RESERVED, INTERMEDIATE CARE - LEVEL 2
000097	A	RESERVED, INTERMEDIATE CARE - LEVEL 3
000098	A	RESERVED, SWING BED
000099	A	RESERVED, RESERVED FOR NATIONAL ASSIGNMENT

Bill Types for Part A and B
(Use the second column for reporting Bill/Subtype)

Provider Type Code	Bill Type Code	Code Range	Description
000001	000001	00100-01999	ANESTHESIA
000001	000002	10040-69999, 0027T, 0032T–0039T, 0046T-0057T, 0061T	SURGERY
000001	000003	70010-79999, 0028T, 0042T	RADIOLOGY
000001	000004	80049-89399, 0006F, 0030T, 0031T, 0040T, 0041T 0043T, 0059T	PATHOLOGY
000001	000005	90281-98939, 0001F, 0009F, 0010F	MEDICAL EXCEPT ANESTHESIA
000001	000006	99141-99199	MED EXCEPT ANESTHESIA
000001	000007	99201-99499	EVALUATION & MANGE
000001	000008	A0000-A0999	TRANSPORTATION SERVICE

Provider Type Code	Bill Type Code	Code Range	Description
000001	000009	A2000-A2999	CHIROPRACTIC
000001	000010	A4000-A8999	DMEPOS – SURGICAL SUPPLIES
000001	000011	B4000-B9999	DMEPOS - ENTERAL AND PARENTERAL
000001	000012	E0100-E2101	DMEPOS – MEDICAL EQUIPMENT
000001	000013	G0000-G9999, 0029T, 0044T, 0060T	MED EXCEPT ANESTHESIA
000001	000014	H5000-H6000	MED EXCEPT ANESTHESIA
000001	000015	K0000-K9999	DMEPOS – DME
000001	000016	L0100-L9999	DMEPOS – ORTHOTICS
000001	000017	M0000-M0799	MED EXCEPT ANESTHESIA
000001	000018	M0900-M0999	ESRD
000001	000019	P2000-P9999	PATHOLOGY
000001	000020	V0000-V5399	MED EXCEPT ANESTHESIA (INCLUDES CORRECTIVE LENSES)
000001	000021	ALL OTHERS	OTHER (INCLUDES 0002F-0005F, 0007F, 0008F, 0011F, 0045T, and 0058T)
000001	999999		FOR PART B POST PAY AND CLAIMS REPORTING
000002	000001	00100-01999	ANESTHESIA
000002	000002	10040-69999, 0027T, 0032T–0039T, 0046T-0057T, 0061T	SURGERY
000002	000003	70010-79999, 0028T, 0042T	RADIOLOGY
000002	000004	80049-89399, 0006F, 0030T, 0031T, 0040T, 0041T 0043T, 0059T	PATHOLOGY
000002	000005	90281-98939, 0001F, 0009F, 0010F	MEDICAL EXCEPT ANESTHESIA
000002	000006	99141-99199	MED EXCEPT ANESTHESIA
000002	000007	99201-99499	EVALUATION & MANGE
000002	000008	A0000-A0999	TRANSPORTATION SERVICE
000002	000009	A2000-A2999	CHIROPRACTIC
000002	000010	A4000-A8999	DMEPOS - SURGICAL SUPPLIES
000002	000011	B4000-B9999	DMEPOS - ENTERAL AND PARENTERAL
000002	000012	E0100-E2101	DMEPOS – MEDICAL EQUIPMENT
000002	000013	G0000-G9999, 0029T, 0044T, 0060T	MED EXCEPT ANESTHESIA
000002	000014	H5000-H6000	MED EXCEPT ANESTHESIA
000002	000015	K0000-K9999	DMEPOS – DME
000002	000016	L0100-L9999	DMEPOS – ORTHOTICS
000002	000017	M0000-M0799	MED EXCEPT ANESTHESIA
000002	000018	M0900-M0999	ESRD
000002	000019	P2000-P9999	PATHOLOGY
000002	000020	V0000-V5399	MED EXCEPT ANESTHESIA (INCLUDES CORRECTIVE LENSES)

Provider Type Code	Bill Type Code	Code Range	Description
000002	000021	ALL OTHERS	OTHER (INCLUDES 0002F-0005F, 0007F, 0008F, 0011F, 0045T, and 0058T)
000002	999999		FOR PART B POST PAY AND CLAIMS REPORTING
000011 – 000099	999999	ALL PART A	FOR ALL PART B RECORDS

f. Crosswalk Between Medicare Summary Notice Messages and PIMR Denial Reason Codes

MSN NUMBER	MSN DESCRIPTION	PIMR CODE
1.1	Air ambulance is not covered since you were not taken to the airport by ambulance.	100003
1.2	Payment is denied because the ambulance company is not approved by Medicare.	100003
1.3	Ambulance service to a funeral home is not covered.	100003
1.4	Transportation in a vehicle other than an ambulance is not covered.	100003
1.5	Transportation to a facility to be closer to home or family is not covered.	100003
1.6	This service is included in the allowance for the ambulance transportation.	100003
1.7	Ambulance services to or from a doctor's office are not covered.	100003
1.8	This service is denied because you refused to be transported.	100003
1.9	Payment for ambulance services does not include mileage when you were not in the ambulance.	100003
1.10	Payment for transportation is allowed only to the closest facility that can provide the necessary care.	100007
1.11	The information provided does not support the need for an air ambulance. The approved amount is based on ground ambulance.	100007
2.1	The first three pints of blood used in each year are not covered.	100003
2.2	Charges for replaced blood are not covered.	100003
3.1	This service is covered only when recent x-rays support the need for the service.	100003
4.1	This charge is more than Medicare pays for maintenance treatment of renal disease.	NOT PI
4.2	This service is covered up to (insert appropriate number) months after transplant and release from the hospital.	100003
4.3	Prescriptions for immunosuppressive drugs are limited to a 30-day supply.	100003
4.4	Only one supplier per month may be paid for these supplies/services.	100003
4.5	Medicare pays the professional part of this charge to the hospital.	100003
4.6	Payment has been reduced by the number of days you were not in the usual place of treatment.	100019
4.7	Payment for all equipment and supplies is made through your dialysis center. They will bill Medicare for these services.	NOT PI
4.8	This service cannot be paid because you did not choose an option for your dialysis equipment and supplies.	NOT PI

4.9	Payment was reduced or denied because the monthly maximum allowance for this home dialysis equipment and supplies has been reached.	100003
4.10	No more than ($) can be paid for these supplies each month. (NOTE: Insert appropriate dollar amount.)	NOT PI
4.11	The amount listed in the "You May Be Billed" column is based on the Medicare approved amount. You are not responsible for the difference between the amount charged and the approved amount.	NOT PI
5.1	Our records show that you do not have Medicare entitlement under the number shown on this notice. If you do not agree, please contact your local Social Security office.	NOT PI
5.2	The name or Medicare number was incorrect or missing. Please check your Medicare card. If the information on this notice is different from your card, contact your provider.	NOT PI
5.3	Our records show that the date of death was before the date of service.	100003
5.4	If you cash the enclosed check, you are legally obligated to make payment for these services. If you do not wish to assume this obligation, please return this check.	NOT PI
5.5	Our records show you did not have Part A (B) coverage when you received this service. If you disagree, please contact us at the customer service number shown on this notice.	NOT PI
5.6	The name or Medicare number was incorrect or missing. Ask your provider to use the name or number shown on this notice for future claims.	NOT PI
6.1	This drug is covered only when Medicare pays for the transplant.	100003
6.2	Drugs not specifically classified as effective by the Food and Drug Administration are not covered.	100007
6.3	Payment cannot be made for oral drugs that do not have the same active ingredients as they would have if given by injection.	100007
6.4	Medicare does not pay for an oral anti-emetic drug that is not administered for use immediately before, at, or within 48 hours after administration of a Medicare covered chemotherapy drug.	100007
7.1	This is a duplicate of a charge already submitted.	NOT PI
7.2	This is a duplicate of a claim processed by another contractor. You should receive a Medicare Summary Notice from them.	NOT PI
8.1	Your supplier is responsible for the servicing and repair of your rented equipment.	100003
8.2	To receive Medicare payment, you must have a doctor's prescription before you rent or purchase this equipment.	100016
8.3	This equipment is not covered because its primary use is not for medical purposes.	100007
8.4	Payment cannot be made for equipment that is the same or similar to equipment already being used.	100007
8.5	Rented equipment that is no longer needed or used is not covered.	100007
8.6	A partial payment has been made because the purchase allowance has been reached. No further rental payments can be made.	NOT PI
8.7	This equipment is covered only if rented.	100003
8.8	This equipment is covered only if purchased.	100003

8.9	Payment has been reduced by the amount already paid for the rental of this equipment.	NOT PI
8.10	Payment is included in the approved amount for other equipment.	100003
8.11	The purchase allowance has been reached. If you continue to rent this piece of equipment, the rental charges are your responsibility.	NOT PI
8.12	The approved charge is based on the amount of oxygen prescribed by the doctor.	100017
8.13	Monthly rental payments can be made for up to 15 months from the first paid rental month or until the equipment is no longer needed, whichever comes first.	NOT PI
8.14	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 6-month period after the end of the 15th paid rental month.	NOT PI
8.15	Maintenance and/or servicing of this item is not covered until 6 months after the end of the 15th paid rental month.	NOT PI
8.16	The approved amount includes payment for all covered stationary oxygen equipment, contents and accessory items for an entire rental month.	100003
8.17	Payment for this item is included in the monthly rental payment amount.	NOT PI
8.18	Payment is denied because the supplier did not have a written order from your doctor prior to delivery of this item.	100016
8.19	Sales tax is included in the approved amount for this item.	NOT PI
8.20	Medicare does not pay for this equipment or item.	100003
8.21	This item cannot be paid without a new, revised or renewed certificate of medical necessity.	100016
8.22	No further payment can be made because the cost of repairs has equaled the purchase price of this item.	100003
8.23	No payment can be made because the item has reached the 15-month limit. Separate payments can be made for maintenance or servicing every 6 months.	100003
8.24	The claim does not show that you own or are purchasing the equipment requiring these parts or supplies.	100003
8.25	Payment cannot be made until you tell your supplier whether you want to rent or buy this equipment.	100003
8.26	Payment is reduced by 25% beginning the 4th month of rental.	100003
8.27	Payment is limited to 13 monthly rental payments because you have decided to purchase this equipment.	100003
8.28	Maintenance, servicing, replacement or repair of this item is not covered.	100003
8.29	Payment is allowed only for the seat lift mechanism, not the entire chair.	100003
8.30	This item is not covered because the doctor did not complete the certificate of medical necessity.	100016
8.31	Payment is denied because blood gas tests cannot be performed by a durable medical equipment supplier.	100003
8.32	This item can only be rented for two months. If the item is still needed, it must be purchased.	100003
8.33	This is the next to last payment for this item.	100003
8.34	This is the last payment for this item.	100003
8.35	This item is not covered when oxygen is not being used.	100003
8.36	Payment is denied because the certificate of medical necessity on file was not in effect for this date of service.	100016

8.37	An oxygen recertification form was sent to the physician.	NOT PI
8.38	This item must be rented for 2 months prior to purchasing it.	100003
8.39	This is the 10th month of rental payment. Your supplier should offer you the choice of changing the rental to a purchase agreement.	100003
8.40	We have previously paid for the purchase of this item.	100003
8.41	Payment for the amount of oxygen supplied has been reduced or denied because the monthly limit has been reached.	100003
8.42	Standby equipment is not covered.	100003
8.43	Payment has been denied because this equipment cannot deliver the liters per minute prescribed by your doctor.	100017
8.44	Payment is based on a standard item because information did not support the need for a deluxe or more expensive item.	100001
8.45	Payment for electric wheelchairs is allowed only if the purchase decision is made in the first or tenth month of rental.	NOT PI
8.46	Payment is included in the allowance for another item or service provided at the same time.	100003
8.47	Supplies or accessories used with no covered equipment are not covered.	100003
8.48	Payment for this drug is denied because the need for the equipment has not been established.	100007
8.49	This allowance has been reduced because part of this item was paid on another claim.	NOT PI
8.50	Medicare cannot pay for this drug/equipment because our records do not show your supplier is licensed to dispense prescription drugs, and, therefore, cannot assure the safety and effectiveness of the drug/equipment. You are not financially liable for any amount for this drug/equipment unless your supplier gave you a written notice in advance that Medicare would not pay for it and you agreed to pay.	100003
9.1	The information we requested was not received.	100004
9.2	This item or service was denied because information required to make payment was missing.	100001
9.3	Please ask your provider to submit a new, complete claim to us. (NOTE: Add-on to other messages as appropriate)	NOT PI
9.4	This item or service was denied because information required to make payment was incorrect.	100005
9.5	Our records show your doctor did not order this supply or amount of supplies.	100014
9.6	Please ask your provider to resubmit this claim with a breakdown of the charges or services.	NOT PI
9.7	We have asked your provider to resubmit the claim with the missing or correct information. (NOTE: Add-on to other messages as appropriate)	NOT PI
9.8	The hospital has been asked to submit additional information, you should not be billed at this time.	NOT PI
10.1	Shoes are only covered as part of a leg brace.	100003
11.1	Your claim has been forwarded to the correct Medicare contractor for processing. You will receive a notice from them. (NOTE: Use for Carriers, Intermediaries, RRB, United Mine Workers)	NOT PI
11.2	This information is being sent to Medicaid. They will review it to see if additional	NOT PI

	benefits can be paid.	
11.3	Our records show that you are enrolled in a health maintenance organization. Your provider must bill this service to them.	NOT PI
11.4	Our records show that you are enrolled in a health maintenance organization. Your claim was sent to them for processing.	NOT PI
11.5	This claim will need to be submitted to (another carrier, a durable medical equipment regional carrier (DMERC), Medicaid agency.)	NOT PI
11.6	We have asked your provider to resubmit this claim to the proper carrier (intermediary). That carrier (intermediary) is (name and address of carrier, intermediary or durable medical equipment regional carrier, etc.)	NOT PI
12.1	Hearing aids are not covered.	100003
13.1	No qualifying hospital stay dates were shown for this skilled nursing facility stay.	100003
13.2	Skilled nursing facility benefits are only available after a hospital stay of at least 3 days.	100003
13.3	Information provided does not support the need for skilled nursing facility care.	100007
13.4	Information provided does not support the need for continued care in a skilled nursing facility.	100007
13.5	You were not admitted to the skilled nursing facility within 30 days of your hospital discharge.	100003
13.6	Rural primary care skilled nursing facility benefits are only available after a hospital stay of at least 2 days. (**NOTE:** This message is used only in connection with hospital stays that occurred prior to October 1, 1997.)	100003
14.1	The laboratory is not approved for this type of test.	100003
14.2	Medicare approved less for this individual test because it can be done as part of a complete group of tests.	100003
14.3	Services or items not approved by the Food and Drug Administration are not covered.	100003
14.4	Payment denied because the claim did not show who performed the test and/or the amount charged.	100001
14.5	Payment denied because the claim did not show if the test was purchased by the physician or if the physician performed the test.	100001
14.6	This test must be billed by the laboratory that did the work.	NOT PI
14.7	This service is paid at 100% of the Medicare approved amount. (**NOTE:** Mandated message - This message must appear on all service lines paid at 100% of the Medicare approved amount.)	NOT PI
14.8	Payment cannot be made because the physician has a financial relationship with the laboratory.	NOT PI
14.9	Medicare cannot pay for this service for the diagnosis shown on the claim.	100007
14.10	Medicare does not allow a separate payment for EKG readings.	100003
14.11	A travel allowance is paid only when a covered specimen collection fee is billed.	100003
14.12	Payment for transportation can only be made if an x-ray or EKG is performed.	100003
14.13	The laboratory was not approved for this test on the date it was performed.	100003
15.1	The information provided does not support the need for this many services or items.	100007

15.2	The information provided does not support the need for this equipment.	100007
15.3	The information provided does not support the need for the special features of this equipment.	100007
15.4	The information provided does not support the need for this service or item.	100007
15.5	The information provided does not support the need for similar services by more than one doctor during the same time period.	100007
15.6	The information provided does not support the need for this many services or items within this period of time.	100007
15.7	The information provided does not support the need for more than one visit a day.	100007
15.8	The information provided does not support the level of service as shown on the claim.	100007
15.9	The peer review organization did not approve this service.	100007
15.10	Medicare does not pay for more than one assistant surgeon for this procedure.	100003
15.11	Medicare does not pay for an assistant surgeon for this procedure/surgery.	100003
15.12	Medicare does not pay for two surgeons for this procedure.	100003
15.13	Medicare does not pay for team surgeons for this procedure.	100003
15.14	Medicare does not pay for acupuncture.	100003
15.15	Payment has been reduced because information provided does not support the need for this item as billed.	100007
15.16	Your claim was reviewed by our medical staff. (**NOTE:** Add-on to other messages as appropriate.)	NOT PI
15.17	We have approved this service at a reduced level. (**NOTE:** Add-on to other messages as appropriate)	NOT PI
16.1	This service cannot be approved because the date on the claim shows it was billed before it was provided.	100001
16.2	This service cannot be paid when provided in this location/facility.	100007
16.3	The claim did not show that this service or item was prescribed by your doctor.	100017
16.4	This service requires prior approval by the peer review organization.	100007
16.5	This service cannot be approved without a treatment plan by a physical or occupational therapist.	100018
16.6	This item or service cannot be paid unless the provider accepts assignment.	NOT PI
16.7	Your provider must complete and submit your claim.	NOT PI
16.8	Payment is included in another service received on the same day.	100003
16.9	This allowance has been reduced by the amount previously paid for a related procedure.	100003
16.10	Medicare does not pay for this item or service.	100003
16.11	Payment was reduced for late filing. You cannot be billed for the reduction. (**NOTE:** Mandated message - This message must print on all service lines subject to the 10% reduction.)	NOT PI
16.12	Outpatient mental health services are paid at 50 percent of the approved charges. (**NOTE:** Mandated message - This message must print on all service lines subject to the outpatient psychiatric reduction when no deductible has been applied.)	NOT PI
16.13	The code(s) your provider used is/are not valid for the date of service billed.	100005

16.14	The attached check replaces your previous check (#) dated .	NOT PI
16.15	The attached check replaces your previous check. (**NOTE:** Use only if prior check information is not accessible by the system.)	NOT PI
16.16	As requested, this is a duplicate copy of your Medicare Summary Notice.	NOT PI
16.17	Medicare does not pay for these services when they are not given in conjunction with total parenteral nutrition.	100003
16.18	Service provided prior to the onset date of certified parenteral/enteral nutrition therapy is not covered.	100003
16.19	The approved amount of this parenteral/enteral nutrition supply is based on a less extensive level of care for the nature of the diagnosis stated.	100005
16.20	The approved payment for calories/grams is the most Medicare may allow for the diagnosis stated.	100007
16.21	The procedure code was changed to reflect the actual service rendered.	100005
16.22	Medicare does not pay for services when no charge is indicated.	NOT PI
16.23	This check is for the excess amount you paid toward a prior overpayment.	NOT PI
16.24	Services provided aboard a ship are covered only when the ship is of United States registry and is in United States waters. In addition, the service must be provided by a doctor licensed to practice in the United States.	100003
16.25	Medicare does not pay for this much equipment, or this many services or supplies.	100009
16.26	Medicare does not pay for services or items related to a procedure that has not been approved or billed.	100003
16.27	This service is not covered since our records show you were in the hospital at this time.	100003
16.28	Medicare does not pay for services or equipment that you have not received.	NOT PI
16.29	Payment is included in another service you have received.	100003
16.30	Services billed separately on this claim have been combined under this procedure.	100003
16.31	You are responsible to pay the primary physician the agreed monthly charge.	NOT PI
16.32	Medicare does not pay separately for this service.	100003
16.33	Your payment includes interest because Medicare exceeded processing time limits. (**NOTE:** Mandated message - This message must print claim level if interest is added into the beneficiary payment amount for unassigned or split pay claims.)	NOT PI
16.34	You should not be billed for this service. You do not have to pay this amount. (**NOTE:** Add-on to other messages, or use individually as appropriate.)	NOT PI
16.35	You do not have to pay this amount. (**NOTE:** Add-on to other messages as appropriate.)	NOT PI
16.36	If you have already paid it, you are entitled to a refund from this provider. (**NOTE:** Add-on to other messages as appropriate.)	NOT PI
16.37	Please see the back of this notice. (**NOTE:** Add-on to other messages as you feel appropriate.)	NOT PI

16.38	Charges are not incurred for leave of absence days.	NOT PI
16.39	Only one provider can be paid for this service per calendar month. Payment has already been made to another provider for this service.	100003
16.40	Only one inpatient service per day is allowed.	100003
16.41	Payment is being denied because you refused to request reimbursement under your Medicare benefits.	NOT PI
16.42	The provider's determination of noncoverage is correct.	100003
16.43	This service cannot be approved without a treatment plan and supervision of a doctor.	100018
16.44	Routine care is not covered.	100003
16.45	You cannot be billed separately for this item or service. You do not have to pay this amount.	100003
16.46	Medicare payment limits do not affect a Native American's right to free care at Indian Health Institutions.	NOT PI
16.47	When deductible is applied to outpatient psychiatric services, you may be billed for up to the approved amount. The "You May Be Billed" column will tell you the correct amount to pay your provider.	NOT PI
17.1	Services performed by a private duty nurse are not covered.	100003
17.2	This anesthesia service must be billed by a doctor.	100003
17.3	This service was denied because you did not receive it under the direct supervision of a doctor.	100003
17.4	Services performed by an audiologist are not covered except for diagnostic procedures.	100003
17.5	Your provider's employer must file this claim and agree to accept assignment.	NOT PI
17.6	Full payment was not made for this service because the yearly limit has been met.	100003
17.7	This service must be performed by a licensed clinical social worker.	100003
17.8	Payment was denied because the maximum benefit allowance has been reached.	100003
17.9	Medicare (Part A/Part B) pays for this service. The provider must bill the correct Medicare contractor. (**NOTE:** Insert appropriate program. Message is used for Part A claims received by Part B or Part B claims received by Part A.)	NOT PI
17.10	The allowance has been reduced because the anesthesiologist medically directed concurrent procedures.	100003
17.11	This item or service cannot be paid as billed.	100005
17.12	This service is not covered when provided by an independent therapist.	100003
17.13	Medicare approves up to ($) a year for services billed by a physical or occupational therapist. (**NOTE:** Insert appropriate dollar amount.)	100003
17.14	Charges for maintenance therapy are not covered.	100007
17.15	This service cannot be paid unless certified by your physician every ( ) days. (**NOTE:** Insert appropriate number of days.)	100016
17.16	The hospital should file a claim for Medicare benefits because these services were performed in a hospital setting.	100003
18.1	Routine examinations and related services are not covered.	100003
18.2	This immunization and/or preventive care is not covered.	100003

18.3	Screening mammography is not covered for women under 35 years of age.	100003
18.4	This service is being denied because it has not been 12 months since your last examination of this kind. (**NOTE:** Insert appropriate number of months.)	100003
18.5	Medicare will pay for another screening mammogram in (12, 24) months. (**NOTE:** Insert appropriate number of months.)	100003
18.6	A screening mammography is covered only once for women age 35 - 39.	100003
18.7	Screening pap smears are covered only once every 36 months unless high risk factors are present.	100003
18.8	Screening mammograms are covered for women 40 - 49 years of age without high risk factors only once every 24 months.	100003
18.9	Screening mammograms are covered for women 40 - 49 years of age with high risk factors only once every 12 months.	100003
18.10	Screening mammograms are covered for women 50 - 64 years of age once every 12 months.	100003
18.11	Screening mammograms are covered for women 65 years of age and older only once every 24 months.	100003
18.12	Screening mammograms are covered annually for woman 40 years of age and older.	100003
18.13	This service is not covered for beneficiaries under 50 years of age.	100003
18.14	Service is being denied because it has not been (12,24,48) months since your last (test/procedure) of this kind.	100003
18.15	Medicare only covers this procedure for beneficiaries considered to be at high risk for colorectal cancer.	100003
18.16	This service is being denied because payment has already been made for a similar procedure within a set timeframe.	100003
18.17	Medicare pays for screening Pap smear and/or screening pelvic examination only once every 3 years unless high risk factors are present.	100003
18.18	Medicare does not pay for this service separately since payment of it is included in our allowance for other services you received on the same day.	100003
19.1	Services of a hospital-based specialist are not covered unless there is an agreement between the hospital and the specialist.	100003
19.2	Payment was reduced because this service was performed in a hospital outpatient setting rather than a provider's office.	100003
19.3	Only one hospital visit or consultation per provider is allowed per day.	100003
20.1	You have used all of your benefit days for this period.	100003
20.2	You have reached your limit of 190 days of psychiatric hospital services.	100003
20.3	You have reached your limit of 60 lifetime reserve days.	100003
20.4	( ) of the Benefit Days Used were charged to your Lifetime Reserve Day benefit. (**NOTE:** Mandated message - This message must be printed claim level when all or a portion of the Benefit Days Used are charged to the Lifetime Reserve Day benefit.)	100003
20.5	These services cannot be paid because your benefits are exhausted at this time.	100003
20.6	Days used has been reduced by the primary group insurer's payment.	100003
20.7	You have ____ day(s) remaining of your 190-day psychiatric limit.	100003
20.8	Days used are being subtracted from your total (inpatient or skilled nursing facility) benefits for this benefit period.	100003

20.9	Services after mm/dd/yy cannot be paid because your benefits were exhausted.	100003
21.1	Services performed by an immediate relative or a member of the same household are not covered.	100003
21.2	The provider of this service is not eligible to receive Medicare payments.	100003
21.3	This provider was not covered by Medicare when you received this service.	100003
21.4	Services provided outside the United States are not covered. See your Medicare Handbook for services received in Canada and Mexico.	100003
21.5	Services needed as a result of war are not covered.	100003
21.6	This item or service is not covered when performed, referred, or ordered by this provider.	100003
21.7	This service should be included on your inpatient bill.	100003
21.8	Services performed using equipment that has not been approved by the Food and Drug Administration are not covered.	100003
21.9	Payment cannot be made for unauthorized service outside the *Medicare Advantage* plan.	100003
21.10	A surgical assistant is not covered for this place and/or date of service.	100003
21.11	This service was not covered by Medicare at the time you received it.	100003
21.12	This hospital service was not covered because the attending physician was not eligible to receive Medicare benefits at the time the service was performed.	100003
21.13	This surgery was not covered because the attending physician was not eligible to receive Medicare benefits at the time the service was performed.	100003
21.14	Medicare cannot pay for this investigational device because the FDA clinical trial period has not begun.	100002
21.15	Medicare cannot pay for this investigational device because the FDA clinical trial period has ended.	100002
21.16	Medicare does not pay for this investigational device.	100003
21.17	Your provider submitted noncovered charges for which you are responsible.	100003
21.18	This item or service is not covered when performed or ordered by this provider.	100003
21.19	This provider decided to drop out of Medicare. No payment can be made for this service, you are responsible for this charge. Under Federal law your doctor cannot charge you more than the limiting charge amount.	100003
21.20	The provider decided to drop-out of Medicare. No payment can be made for this service, you are responsible for this charge.	100003
22.1	Your claim was separated for processing. The remaining services may appear on a separate notice.	NOT PI
23.1	The cost of care before and after the surgery or procedure is included in the approved amount for that service.	100003
23.2	Cosmetic surgery and related services are not covered.	100003
23.3	Medicare does not pay for surgical supports except primary dressings for skin grafts.	100003
23.4	A separate charge is not allowed because this service is part of the major surgical procedure.	100003
23.5	Payment has been reduced because a different doctor took care of you before and/or after the surgery.	100003
23.6	This surgery was reduced because it was performed with another surgery on the same day.	100003

23.7	Payment cannot be made for an assistant surgeon in a teaching hospital unless a resident doctor was not available.	100003
23.8	This service is not payable because it is part of the total maternity care charge.	100003
23.9	Payment has been reduced because the charges billed did not include post-operative care.	100003
23.10	Payment has been reduced because this procedure was terminated before anesthesia was started.	100003
23.11	Payment cannot be made because the surgery was canceled or postponed.	NOT PI
23.12	Payment has been reduced because the surgery was canceled after you were prepared for surgery.	NOT PI
23.13	Because you were prepared for surgery and anesthesia was started, full payment is being made even though the surgery was canceled.	NOT PI
23.14	The assistant surgeon must file a separate claim for this service.	NOT PI
23.15	The approved amount is less because the payment is divided between two doctors. (**NOTE:** use for global reductions.)	NOT PI
23.16	An additional amount is not allowed for this service when it is performed on both the left and right sides of the body.	100003
24.1	Protect your Medicare number as you would a credit card number.	NOT PI
24.2	Beware of telemarketers or advertisements offering free or discounted Medicare items and services.	NOT PI
24.3	Beware of door-to-door solicitors offering free or discounted Medicare items or services.	NOT PI
24.4	Only your physician can order medical equipment for you.	100014
24.5	Always review your Medicare Summary Notice for correct information about the items or services you received.	NOT PI
24.6	Do not sell your Medicare number or Medicare Summary Notice.	NOT PI
24.7	Do not accept free medical equipment you don't need.	NOT PI
24.8	Beware of advertisements that read, "This item is approved by Medicare", or "No out-of-pocket expenses."	NOT PI
24.9	Be informed - Read your Medicare Summary Notice.	NOT PI
24.10	Always read the front and back of your Medicare Summary Notice.	NOT PI
24.11	Beware of Medicare scams, such as offers of free milk or cheese for your Medicare number.	NOT PI
24.12	Read your Medicare Summary Notice carefully for accuracy of dates, services, and amounts billed to Medicare.	NOT PI
24.13	Be sure you understand anything you are asked to sign.	NOT PI
24.14	Be sure any equipment or services you received were ordered by your doctor.	100014
25.1	This claim was denied because it was filed after the time limit.	NOT PI

25.2	You can be billed only 20 percent of the charges that would have been approved.	NOT PI
26.1	Eye refractions are not covered.	100003
26.2	Eyeglasses or contact lenses are covered only after cataract surgery or if the natural lens of your eye is missing.	100003
26.3	Only one pair of eyeglasses or contact lenses is covered after cataract surgery with lens implant.	100003
26.4	This service is not covered when performed by this provider.	100003
26.5	This service is covered only in conjunction with cataract surgery.	100003
26.6	Payment was reduced because the service was terminated early.	100003
27.1	This service is not covered because you are enrolled in a hospice.	100003
27.2	Medicare will not pay for inpatient respite care when it exceeds five (5) consecutive days at a time.	100003
27.3	The physician certification requesting hospice services was not received timely.	100013
27.4	The documentation received indicates that the general inpatient services were not related to the terminal illness. Therefore, payment will be adjusted to the routine home care rate.	100007
27.5	Payment for the day of discharge from the hospital will be made to the hospice agency at the routine home care rate.	100003
27.6	The documentation indicates the level of care was at the respite level not the general inpatient level of care. Therefore, payment will be adjusted to the routine home care rate.	100007
27.7	According to Medicare hospice requirements, the hospice election consent was not signed timely.	100019
27.8	The documentation submitted does not support that your illness is terminal.	100007
27.9	The documentation indicates your inpatient level of care was not reasonable and necessary. Therefore, payment will be adjusted to the routine home care rate.	100007
27.10	The documentation indicates that the level of continuous care was not reasonable and necessary. Therefore, payment will be adjusted to the routine home care rate.	100007
27.11	The provider has billed in error for the routine home care items or services received.	100019
28.1	Because you have Medicaid, your provider must agree to accept assignment.	NOT PI
29.1	Secondary payment cannot be made because the primary insurer information was either missing or incomplete.	NOT PI
29.2	No payment was made because your primary insurer's payment satisfied the provider's bill.	NOT PI
29.3	Medicare benefits are reduced because some of these expenses have been paid by your primary insurer.	NOT PI
29.4	In the future, if you send claims to Medicare for secondary payment, please send them to (carrier MSP address).	NOT PI
29.5	Our records show that Medicare is your secondary payer. This claim must be sent to your primary insurer first. (**NOTE:** Use "Add-on" message as appropriate.)	NOT PI

29.6	Our records show that Medicare is your secondary payer. Services provided outside your prepaid health plan are not covered. We will pay this time only since you were not previously notified.	NOT PI
29.7	Medicare cannot pay for this service because it was furnished by a provider who is not a member of your employer prepaid health plan. Our records show that you were informed of this rule.	NOT PI
29.8	This claim is denied because the service(s) may be covered by the worker''s compensation plan. Ask your provider to submit a claim to that plan.	NOT PI
29.9	Since your primary insurance benefits have been exhausted, Medicare will be primary on this accident related service.	NOT PI
29.10	These services cannot be paid because you received them on or before you received a liability insurance payment for this injury or illness.	NOT PI
29.11	Our records show that an automobile medical, liability, or no-fault insurance plan is primary for these services. Submit this claim to the primary payer. (NOTE: Use "Add-on" message as appropriate.)	NOT PI
29.12	Our records show that these services may be covered under the Black Lung Program. Contact the Federal Black Lung Program, P.O. Box 828, Lanham-Seabrook, MD 20703-0828. (**NOTE:** Use "Add-on" message as appropriate.)	NOT PI
29.13	Medicare does not pay for these services because they are payable by another government agency. Submit this claim to that agency. (NOTE: Use "Add-on" message as appropriate.)	NOT PI
29.14	Medicare's secondary payment is ($). This is the difference between the primary insurer's approved amount of ($) and the primary insurer's paid amount of ($). (**NOTE:** Mandated message - This message should print claim level when a Medicare secondary payment is made and the primary insurer's approved amount is higher than Medicare's approved amount. Do not print when the claim paid amount is equal to the amount Medicare would pay if services were not covered by a third party payer.)	NOT PI
29.15	Medicare's secondary payment is ($). This is the difference between Medicare's approved amount of ($) and the primary insurer's paid amount of ($). (NOTE: Mandated message - This message should print claim level when a Medicare secondary payment is made and Medicare's approved amount is higher than the primary insurer's approved amount. Do not print when the claim paid amount is equal to the amount Medicare would pay if services were not covered by a third party payer.)	NOT PI
29.16	Your primary insurer approved and paid ($) on this claim. Therefore, no secondary payment will be made by Medicare. (**NOTE:** Mandated message - This message should print claim or service level when the primary insurer's approved amount is higher than Medicare's approved amount and the primary payment is equal to the approved amount. Do not print on denied service lines.)	NOT PI
29.17	Your provider agreed to accept ($) as payment in full on this claim. Your primary insurer has already paid ($) so Medicare's payment is the difference between the two amounts. (**NOTE:** Mandated message - This message should print claim level when the provider is obligated to accept less than the Medicare approved amount.)	NOT PI

29.18	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. (**NOTE:** Mandated message - This message should print on all assigned MSP service lines when Medicare secondary payment was made. Print message on assigned service lines for full recoveries. Do not print on denied service lines.)	NOT PI
29.19	The amount listed in the "You May Be Billed" column assumes that your primary insurer paid you. If your primary insurer paid the provider, then you only need to pay the provider the difference between the amount charged and the amount the primary insurer paid. (**NOTE:** Mandated message - This message should print on all unassigned MSP service lines when Medicare secondary payment was made. Print message on unassigned service lines for full recoveries. Do not print on denied service lines. Do not print when conditions in 29.20 or 29.22 are met.)	NOT PI
29.20	The amount listed in the "You May Be Billed" column assumes that your primary insurer paid you. If your primary insurer paid the provider, then you only need to pay the provider the difference between the amount the provider agreed to accept and the amount the primary insurer paid. (**NOTE:** This message should print on all unassigned MSP service lines when the provider is obligated to accept less than the Medicare approved amount. Do not print on denied service lines.)	NOT PI
29.21	The amount listed in the "You May Be Billed" column assumes that your primary insurer made no payment for this service. If your primary insurer did make payment for this service, the amount you may be billed is the difference between the amount charged and the primary insurer's payment. (**NOTE:** Mandated message - This message should print on all Medicare disallowed services for which the beneficiary is liable and the service has been submitted on a claim indicating there has been a primary insurer payment made.)	NOT PI
29.22	The amount listed in the "You May Be Billed" column assumes that your primary insurer paid you. If your primary insurer paid the provider, then you only need to pay the provider the difference between the amount the provider can legally charge and the amount the primary insurer paid. See Note ( ) for the legal charge limit. (**NOTE:** This message should print on all unassigned MSP service lines when a Medicare secondary payment is made and the provider has exceeded the limiting charge.)	NOT PI
29.23	No payment can be made because payment was already made by either workers' compensation or the Federal Black Lung Program.	NOT PI
29.24	No payment can be made because payment was already made by another government entity.	NOT PI
29.25	Medicare paid all covered services not paid by other insurer.	NOT PI
29.26	The primary payer is . (NOTE: Add-on to messages as appropriate and/or as your system permits.)	NOT PI
29.27	Your primary group's payment satisfied Medicare deductible and coinsurance.	NOT PI
29.28	Your responsibility on this claim has been reduced by the amount paid by your primary insurer.	NOT PI

29.29	Your provider is allowed to collect a total of ($) on this claim. Your primary insurer paid ($) and Medicare paid ($). You are responsible for the unpaid portion of ($).	NOT PI
29.30	($) of the money approved by your primary insurer has been credited to your Medicare Part B (A) deductible. You do not have to pay this amount.	NOT PI
29.31	Resubmit this claim with the missing or correct information.	NOT PI
29.32	Medicare's secondary payment is ($). This is the difference between Medicare's limiting charge amount of ($) and the primary insurer's paid amount of ($).	NOT PI
30.1	The approved amount is based on a special payment method.	NOT PI
30.2	The facility fee allowance is greater than the billed amount.	NOT PI
30.3	Your doctor did not accept assignment for this service. Under Federal law, your doctor cannot charge more than ($). If you have already paid more than this amount, you are entitled to a refund from the provider. (NOTE: This message should print on all unassigned service lines for which the billed amount exceeds the Medicare limiting charge. Do not print when the amount the limiting charge is exceeded is less than any threshold established by CMS.)	NOT PI
30.4	A change in payment methods has resulted in a reduced or zero payment for this procedure.	NOT PI
31.1	This is a correction to a previously processed claim and/or deductible record.	NOT PI
31.2	A payment adjustment was made based on a telephone review.	NOT PI
31.3	This notice is being sent to you as the result of a reopening request.	NOT PI
31.4	This notice is being sent to you as the result of a fair hearing request.	NOT PI
31.5	If you do not agree with the Medicare approved amount(s) and $100 or more is in dispute (less deductible and coinsurance), you may ask for a hearing. You must request a hearing within 6 months of the date of this notice. To meet the limit you may combine amounts on other claims that have been reviewed. At the hearing, you may present any new evidence which could affect the decision. Call us at the number in the Customer Service block if you need more information about the hearing process.	NOT PI
31.6	A payment adjustment was made based on a peer review organization request.	100007
31.7	This claim was previously processed under an incorrect Medicare claim number or name. Our records have been corrected.	NOT PI
31.8	This claim was adjusted to reflect the correct provider.	NOT PI
31.9	This claim was adjusted because there was an error in billing.	NOT PI
31.10	This is an adjustment to a previously processed charge (s). This notice may not reflect the charges as they were originally submitted.	NOT PI

31.11	The previous notice we sent stated that your doctor could not charge more than ($). This additional payment allows your doctor to bill you the full amount charged. (NOTE: Mandated message - This message should print service level, as appropriate, when limiting charge applies.)	NOT PI
31.12	The previous notice we sent stated the amount you could be charged for this service. This additional payment changed that amount. Your doctor cannot charge you more than ($).	NOT PI
31.13	The Medicare paid amount has been reduced by ($) previously paid for this claim. (NOTE: Mandated message - This message should print claim level on all adjustments for which a partial payment was previously made.)	NOT PI
31.14	This payment is the result of an Administrative Law Judge's decision.	NOT PI
31.15	An adjustment was made based on a review decision.	NOT PI
31.16	An adjustment was made based on a reconsideration.	NOT PI
32.1	($) dollars of this payment has been withheld to recover a previous overpayment. (**NOTE:** Mandated message - This message should print claim level when the beneficiary check amount is reduced to recover a previous overpayment. Fill in the blank with the amount withheld on the claim at issue.)	NOT PI
33.1	The ambulatory surgical center must bill for this service.	NOT PI
34.1	Of the total ($) paid on this claim, we are paying you ($) because you paid your provider more than your 20 percent co-insurance on Medicare approved services. The remaining ($) was paid to the provider. (NOTE: Mandated message - This message should print claim level on all assigned claims generating payment to the beneficiary.)	NOT PI
34.2	The amount in the "You May Be Billed" column has been reduced by the amount you paid the provider at the time the services were rendered. (NOTE: Mandated message - This message should print claim level on all assigned claims with a beneficiary paid amount that does not exceed coinsurance and deductible and for all unassigned claims submitted with a beneficiary paid amount.)	NOT PI
34.3	After applying Medicare guidelines and the amount you paid to the provider at the time the services were rendered, our records indicate you are entitled to a refund. Please contact your provider. (**NOTE:** Mandated message: This message should print claim level on assigned claims with a split payment to the beneficiary under $1.00.) (**NOTE:** Use this message only when your system cannot plug the dollar amount in message 34.8.)	NOT PI
34.4	We are paying you ($) because the amount you paid the provider was more than you may be billed for Medicare approved charges.	NOT PI
34.5	The amount owed you is ($). Medicare does not routinely issue checks for amounts under $1.00. This amount due will be included in your next check. If you want this money issued immediately, please contact us at the address or phone number in the Customer Service Information Box.	NOT PI
34.6	Your check includes ____ which was withheld on a prior claim.	NOT PI

34.7	This check includes an amount less than $1.00 which was withheld on a prior claim. (**NOTE:** Use this message only when your system cannot plug the dollar amount in message 34.6.)	NOT PI
34.8	The amount you paid the provider for this claim was more than the required payment. You should be receiving a refund of $.XX from your provider, which is the difference between what you paid and what you should have paid. (NOTE: Mandated message: This message should print claim level on assigned claims with a split payment to the beneficiary under $1.00.)	NOT PI
35.1	This information is being sent to your private insurer(s). Send any questions regarding your benefits to them. (**NOTE:** Add if possible : Your private insurer(s) is/are .)	NOT PI
35.2	We have sent your claim to your Medigap insurer. Send any questions regarding your benefits to them. (**NOTE:** Add if possible: Your Medigap insurer is .)	NOT PI
35.3	A copy of this notice will not be forwarded to your Medigap insurer because the information was incomplete or invalid. Please submit a copy of this notice to your Medigap insurer.	NOT PI
35.4	A copy of this notice will not be forwarded to your Medigap insurer because your provider does not participate in the Medicare program. Please submit a copy of this notice to your Medigap insurer.	NOT PI
35.5	We did not send this claim to your private insurer. They have indicated no additional payment can be made. Send any questions regarding your benefits to them.	NOT PI
35.6	Your supplemental policy is not a Medigap policy under Federal and State law/regulation. It is your responsibility to file a claim directly with your insurer.	NOT PI
35.7	Please do not submit this notice to them. (**NOTE:** Add-on to other messages as appropriate)	NOT PI
36.1	Our records show that you were informed in writing, before receiving the service, that Medicare would not pay. You are liable for this charge. If you do not agree with this statement, you may ask for a review.	NOT PI
36.2	It appears that you did not know that we would not pay for this service, so you are not liable. Do not pay your provider for this service. If you have paid your provider for this service, you should submit to this office three things: 1) a copy of this notice, 2) your provider's bill; and 3) a receipt or proof that you have paid the bill. You must file your written request for payment within 6 months of the date of this notice. Future services of this type provided to you will be your responsibility.	100007
36.3	Your provider has been notified that you are due a refund if you paid for this service. If you do not receive a refund from the provider within 30 days from your receipt of this notice, please write our office and include a copy of this notice. Your provider has the right to appeal this decision, which may change your right to a refund.	NOT PI
36.4	This payment refunds the full amount you paid to your provider for the services previously processed and denied. You are entitled to this refund because your provider did not tell you in writing before providing the service(s) that Medicare would not pay for the denied service (s). In the future, you will have to pay for this service when it is denied.	NOT PI

36.5	This payment refunds the full amount you are entitled to for services previously processed and reduced. You are entitled to this refund because your provider did not tell you in writing before providing the service (s) that Medicare would approve it at a lower amount. In the future, you will have to pay for the service as billed when it is reduced.	NOT PI
36.6	Medicare is paying this claim, this time only, because it appears that neither you nor the provider knew that the service(s) would be denied. Future services of this type provided to you will be your responsibility.	NOT PI
37.1	This approved amount has been applied toward your deductible. (**NOTE:** Mandated message - This message should print on each service line with the total approved amount applied to the deductible.)	NOT PI
37.2	($) of this approved amount has been applied toward your deductible. (**NOTE:** Mandated message - This message should print on each service line with a portion of the approved amount applied to the deductible.)	NOT PI
37.3	( ) was applied to your inpatient deductible. (**NOTE:** Mandated message - This message should print on all Part A line items with all, or a portion of the approved amount applied to the inpatient deductible.)	NOT PI
37.4	( ) was applied to your inpatient coinsurance.	NOT PI
37.5	( ) was applied to your skilled nursing facility coinsurance.	NOT PI
37.6	( ) was applied to your blood deductible.	NOT PI
37.7	Part B cash deductible does not apply to these services.	NOT PI
37.8	Coinsurance amount includes outpatient mental health treatment limitation.	NOT PI
37.9	You have now met ($) of your ($) Part B deductible for (year).	NOT PI
37.10	You have now met ($) of your ($) Part A deductible for this benefit period.	NOT PI
37.11	You have met the Part B deductible for (year).	NOT PI
37.12	You have met the Part A deductible for this benefit period.	NOT PI
37.13	You have met the blood deductible for (year).	NOT PI
37.14	You have met ( ) pint(s) of your blood deductible for (year).	NOT PI
38.1	If you think Medicare was billed for something you did not receive, please call our Fraud Hotline, (phone number of Fraud Hotline).	NOT PI
38.2	If you were offered free items or services but Medicare was billed, please call our Fraud Hotline, (phone number of Fraud Hotline)	NOT PI
38.3	If you change your address, please contact (contractor's name) by calling (contractor's phone) and the Social Security Administration by calling 1-800-772-1213.	NOT PI
39 -- 9.3	Please ask your provider to submit a new complete claim to us. (**NOTE:** Add-on to other messages as appropriate.)	NOT PI

39 -- 9.7	We have asked your provider to resubmit the claim with the missing or correct information. (**NOTE:** Add-on to other messages as appropriate.)	NOT PI
39 -- 15.16	Your claim was reviewed by our Medicare staff. (**NOTE:** Add-on to other messages as appropriate.)	NOT PI
39 -- 15.17	We have approved this service at a reduced level. (**NOTE:** Add-on to other messages as appropriate.)	NOT PI
39 -- 16.34	You should not be billed for this item or service. You do not have to pay this amount. (**NOTE:** Add-on to other messages, or use individually as appropriate.)	NOT PI
39 -- 16.35	You do not have to pay this amount. (**NOTE:** Add-on to other messages as appropriate.)	NOT PI
39 -- 16.36	If you have already paid it, you are entitled to a refund from this provider. (**NOTE:** Add-on to other messages as appropriate.)	NOT PI
39 -- 16.37	Please see the back of this notice. (**NOTE:** Add-on to other messages as you feel appropriate.)	NOT PI
39 -- 16.45	You cannot be billed separately for this item or service. You do not have to pay this amount.	NOT PI
39 -- 25.20	You can be billed only 20 percent of the charges that would have been approved. (**NOTE:** Add-on to 25.1 for assigned claims.)	NOT PI
39 -- 29.26	The primary payer is. (**NOTE:** Add-on to other messages as appropriate.)	100004
39 -- 29.31	Resubmit this claim with the missing or correct information.	NOT PI
39 --35.701	Please do not submit this notice to them. (**NOTE:** Add-on to other messages as appropriate)	NOT PI
40 -- 14.7	This service is paid at 100% of the Medicare approved amount. (**NOTE:** Mandated message -This message must appear on all service lines paid at 100% of the Medicare approved amount.)	NOT PI
40 -- 16.11	Payment was reduced for late filing. You cannot be billed for the reduction. (**NOTE:** Mandated message - This message must print on all service lines subject to the 10% reduction.)	NOT PI
40 -- 16.12	Outpatient mental health services are paid at 50 percent of the approved charges. (**NOTE:** Mandated message - This message must print on all service lines subject to the outpatient psychiatric reduction.)	NOT PI
40 -- 16.33	Your payment includes interest because Medicare exceeded processing time limits. (**NOTE:** Mandated message - This message must print claim level if interest is added into the beneficiary payment amount for unassigned or split pay claims.)	NOT PI
40 -- 20.40	( ) of the Benefit Days Used were charged to your Lifetime Reserve Day benefit. (**NOTE:** Mandated message - This message must be printed claim level when all or a portion of the Benefit Days Used are charged to the Lifetime Reserve Day benefit.)	NOT PI

40 -- 29.14	Medicare's secondary payment is ($). This is the difference between the primary insurer's approved amount of ($) and the primary insurer's paid amount of ($). (**NOTE:** Mandated message - This message should print claim level when a Medicare secondary payment is made and the primary insurer's approved amount is higher than Medicare's approved amount. Do not print when the claim paid amount is the amount Medicare would pay if services were not covered by a third party insurer.)	NOT PI
40 -- 29.15	Medicare's secondary payment is ($). This is the difference between Medicare's approved amount of ($) and the primary insurer's paid amount of ($). (**NOTE:** Mandated message - This message should print claim level when a Medicare secondary payment is made and Medicare's approved amount is higher than the primary insurer's approved amount. Do not print when the claim paid amount is equal to the amount Medicare would pay if services were not covered by a third party payer.)	NOT PI
40 -- 29.16	Your primary insurer approved and paid ($) on this claim. Therefore, no secondary payment will be made by Medicare. (**NOTE:** Mandated message - This message should print claim or service level when the primary insurer's approved amount is higher than Medicare's approved amount and the primary payment is equal to the approved amount. Do not print on denied service lines.)	NOT PI
40 -- 29.17	Your provider agreed to accept ($) as payment in full on this claim. Your primary insurer has already paid ($) so Medicare's payment is the difference between the two amounts. (**NOTE:** Mandated message - This message should print claim level when the provider is obligated to accept less than the Medicare approved amount.)	NOT PI
40 -- 29.18	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. (**NOTE:** Mandated message - This message should print on all assigned MSP service lines when Medicare secondary payment was made. Print message on assigned service lines for full recoveries. Do not print on denied service lines.)	NOT PI
40 -- 29.19	The amount listed in the "You May Be Billed" column assumes that your primary insurer paid you. If your primary insurer paid the provider, then you only need to pay the provider the difference between the amount charged and the amount the primary insurer paid. (**NOTE:** Mandated message - This message should print on all unassigned MSP service lines when Medicare secondary payment was made. Print message on unassigned service lines for full recoveries. Do not print on denied service lines. Do not print when conditions in 29.20 or 29.22 are met.)	NOT PI
40 -- 29.20	The amount listed in the "You May Be Billed" column assumes that your primary insurer paid you. If your primary insurer paid the provider, then you only need to pay the provider the difference between the amount the provider agreed to accept and the amount the primary insurer paid. (**NOTE:** This message should print on all unassigned MSP service lines when the provider is obligated to accept less than the Medicare approved amount. Do not print on denied service lines.)	NOT PI

40 -- 29.21	The amount listed in the "You May Be Billed" column assumes that your primary insurer made no payment for this service. If your primary insurer did make payment for this service, the amount you may be billed is the difference between the amount charged and the primary insurer's payment. (**NOTE:** Mandated message - This message should print on all Medicare disallowed services for which the beneficiary is liable and the service has been submitted on a claim indicating there has been a primary insurer payment made.)	NOT PI
40 -- 29.22	The amount listed in the "You May Be Billed" column assumes that your primary insurer paid you. If your primary insurer paid the provider, then you only need to pay the provider the difference between the amount the provider can legally charge and the amount the primary insurer paid. See note ( ) for the legal charge limit. (**NOTE:** This message should print on all unassigned MSP service lines when a Medicare secondary payment is made and the provider has exceeded the limiting charge.)	NOT PI
40 -- 30.3	Your doctor did not accept assignment for this service. Under Federal law, your doctor cannot charge more than ($). If you have already paid more than this amount, you are entitled to a refund from the provider. (**NOTE:** This message should print on all assigned service line for which the billed amount exceeds the Medicare limiting charge. Do not print when the amount of the limiting charge is exceeded is less than the threshold estimated by CMS.)	NOT PI
40 -- 31.11	The previous notice we sent stated that your doctor could not charge more than ($). This additional payment allows your doctor to bill you the full amount charged. (**NOTE:** Mandated message - This message should print claim level, as appropriate, when limiting charge applies.)	NOT PI
40 -- 31.12	The previous notice we sent stated the amount you could be charged for this service. This additional payment changed that amount. Your doctor cannot charge you more than ($). (**NOTE:** Mandated message - This message should print claim level, as appropriate, when limiting charge applies.)	NOT PI
40 -- 31.13	The Medicare paid amount has been reduced by ($) previously paid for this claim. (**NOTE:** Mandated message - This messages should printed claim level on all adjustments for which a partial payment was previously made.)	NOT PI
40 -- 32.1	($) dollars of this payment has been withheld to recover a previous overpayment. (**NOTE:** Mandated message - This message should print claim level when the beneficiary check amount is reduced to recover a previous overpayment. Fill in the blank with the amount withheld on the claim at issue.)	NOT PI
40 -- 34.1	Of the total ($) paid on this claim, we are paying you ($) because you paid your provider more than your 20 percent coinsurance on Medicare approved services. The remaining ($) was paid to the provider. (**NOTE:** Mandated message - This message should print claim level on all assigned split pay claims.)	NOT PI
40 -- 34.2	The amount in the "You May Be Billed" column has been reduced by the amount you paid the provider at the time the services were rendered. (**NOTE:** Mandated message - This message should print claim level on all assigned claims with a beneficiary paid amount that does not exceed coinsurance and deductible and for all unassigned claims submitted with a beneficiary paid amount.)	NOT PI

40 --	34.3	After applying Medicare guidelines and the amount you paid to the provider at the time the services were rendered, our records indicate you are entitled to a refund. Please contact your provider. (**NOTE:** Mandated message: This message should print claim level on assigned claims with a split payment to the beneficiary under $1.00.)	NOT PI
40 --	34.30	After applying Medicare guidelines and the amount you paid to the provider at the time the services were rendered, our records indicate you are entitled to a refund. Please contact your provider. (**NOTE:** Mandated message: This message should print on assigned claims with a split payment to the beneficiary under $1.00.)	NOT PI
40 --	34.8	The amount you paid the provider for this claim was more than the required payment. You should be receiving a refund of $.XX from your provider, which is the difference between what you paid and what you should have paid. (**NOTE:** Mandated message: This message should print claim level on assigned claims with a split payment to the beneficiary under $1.00.)	NOT PI
40 --	37.1	This approved amount has been applied toward your deductible. (**NOTE:** Mandated message - This message should print on each service line with the total approved amount applied to the deductible.)	NOT PI
40 --	37.2	($) of this approved amount has been applied toward your deductible. (**NOTE:** Mandated message - This message should print on each service line with a portion of the approved amount applied to the deductible.)	NOT PI
40 --	37.3	( ) was applied to your inpatient deductible. (**NOTE:** Mandated message - This message should print on all Part A line items with all, or a portion of the approved amount applied to the inpatient deductible.) Print the following messages in the "Deductible Section of all MSNs.	NOT PI
40 --	37.9	You have now met ($) of your ($) Part B deductible for (year).	NOT PI
40 --	37.10	You have now met ($) of your ($) Part A deductible for this benefit period.	NOT PI
40 --	37.11	You have met the Part B deductible for (year).	NOT PI
40 --	37.12	You have met the Part A deductible for this benefit period.	NOT PI
40 --	37.13	You have met the blood deductible for (year).	NOT PI
40 --	37.14	You have met ( ) pints of your blood deductible.	NOT PI
41.1		Medicare will pay for this service only when it is provided in addition to other services.	100003
41.2		This service must be performed by a nurse with the required psychiatric nurse credentials.	100003
41.3		The medical information did not support the need for continued services.	100007
41.4		This item is not considered by Medicare to be appropriate for home use.	100007
41.5		Medicare does not pay for comfort or convenience items.	100003
41.6		This item was not furnished under a plan of care established by your physician.	100015
41.7		This item is not considered by Medicare to be a prosthetic and/or orthotic device.	100003

41.8	Based on the information provided, your illness or injury did not prevent you from leaving your home unaided.	100012
41.9	Services exceeded those ordered by your physician.	100014
41.10	Patients eligible to receive home health benefits from another government agency are not eligible to receive Medicare benefits for the same service.	100003
41.11	Doctors orders were incomplete.	100017
41.12	The provider has billed in error for items/services according to the medical record.	100019
41.13	The provider has billed for services/items not documented in your record.	100006
41.14	This service/item was billed incorrectly.	100005
41.15	The information shows that you can do your own personal care.	100007
41.16	To receive Medicare payment, you must have a signed doctor's order before you receive the services.	100014
60.1	In partnership with physicians in your area, is participating in a Medicare demonstration project that uses a simplified payment method to combine all hospital and physician care related to your hospital service.	NOT PI
60.2	The total Medicare approved amount for your hospital service is _____. Is the Part A Medicare amount for hospital services and _____ is the Part B Medicare amount for physician services (of which Medicare pays 80%). You are responsible for any deductible and coinsurance amounts represented.	NOT PI
60.3	Medicare has paid _____ for hospital and physician services. Your Part A deductible is _____. Your Part A coinsurance is _____. Your Part B coinsurance is _____.	NOT PI
60.4	This claim is being processed under a demonstration project.	NOT PI

11.1.4.1 - MIP CERT Support (Activity Code 21901)

(Rev.220, Issued: 08-24-07, Effective: 09-03-07, Implementation: 09-03-07)

Report the costs associated with time spent on MIP CERT Support Activities. These activities include but are not limited to the following:

- Providing review information to the CERT contractor as described in IOM Pub.. 100-08, ch.12 § 3.3.2.

- Providing feedback information to the CERT contractor as described in IOM Pub.. 100-08, ch.12, § 3.3.3 including but not limited to:

    + CMD discussions about CERT findings;

    + Participation in biweekly CERT conference calls;

    + Responding to inquiries from the CERT contractor; and

    + Preparing dispute cases.

- Preparing the Error Rate Reduction Plan (ERRP) as described in IOM Pub..100-08, ch. 12, §3.9 (Do not include costs of developing MR Strategy or the Quarterly Strategy Analysis (QSA). The cost of developing the MR Strategy and QSA shall be captured in MR CAFM code 21207).

- Educating the provider community about CERT as described in IOM Pub.. 100-08, ch.12, § 3.8.

- Contacting non-responders and referring recalcitrant non-responders to the OIG as described in IOM Pub.. 100-08, ch.12, § 3.*10*.

Contractors shall NOT report costs associated with the following activities in this activity code:

- Providing sample information to the CERT Contractor as described in IOM Pub.. 100-08, ch. 12, § 3.3.1A&B (These costs should be allocated to the PM CERT Support Code – 12901 -- described in the Appeals BPR);

- Ensuring that the correct provider address is supplied to the CERT Contractor as described in IOM Pub.. 100-08, ch. 12, § 3.3.1.C (These costs should be allocated to the PM CERT Support Code – 12901 -- described in the Appeals BPR);

- Researching ‘no resolution’ cases as described in IOM Pub.. 100-08, ch. 12, § 3.3.1.B (These costs should be allocated to the PM CERT Support Code – 12901 -- described in the Appeals BPR);

Medicare Program Integrity Manual
Exhibits

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(Rev. 220, 08-24-07)

Exhibit 2 – Reserved for Future Use

(Rev.220, Issued: 08-24-07, Effective: 09-03-07, Implementation: 09-03-07)

3.1 - Physicians

(Rev.220, Issued: 08-24-07, Effective: 09-03-07, Implementation: 09-03-07)

Medicare defines physicians as:

- Doctors of medicine;
- Doctors of osteopathy;
- Doctors of dental surgery or dental medicine;
- Chiropractors;
- Doctors of podiatry or surgical chiropody; and
- Doctors of optometry.

Do not include other practitioners on this committee.

Carriers select committee representatives from names recommended by State medical societies and specialty societies. If the CMD is concerned because of identified utilization/MR problems with an individual who has been recommended as a committee representative, the CMD should discuss the recommendation with the nominating body. They must maintain confidentiality of the specifics of the situation in any discussion.

If there is no organized specialty society for a particular specialty, the CMD should work with the State medical society to determine how the specialty is to be represented. Encourage each State medical society and specialty society to nominate representatives to the CAC.

If there are multiple specialty societies representing a specialty, select only one representative. Encourage specialty societies to work together to determine how a representative is selected and how that representative communicates with each society.

The CMDs who become committee members or are appointed or elected as officers in any state or national medical society or other professional organization must provide written notice of membership, election, or appointment to CO and RO, as well as to the CAC within 3 months of the membership, election, or appointment effective date. This notice can be provided as part of the CAC minutes if the CMD chooses to give CAC notice via the CAC meeting forum, provided that the CAC meeting is held within the 3-month notice period.

Attempt to include, as members of your CAC, physician representatives from each of the following groups:

- State medical and osteopathic societies (president or designee);

- National Medical Association (representative of either the local or State chapter or its equivalent, if one exists); and

- Medicare *Medicare Advantage* organizations. In order to enhance the consistency of decision making between Medicare *Medicare Advantage* plans and traditional fee-for-service, Medicare *Medicare Advantage* organizations shall also have representation on the CAC. The number of *Medicare Advantage* representatives on the CAC should be based on the Medicare penetration (enrollment) rates for that State; one representative for those States with penetration rates of less than 5 percent and two representatives for those States with penetration rates of 5 percent or higher. The State HMO association should periodically submit nominees for membership on the CAC.

- Physician representatives for each of the following: 1) Chiropractic; 2) Maxillofacial/Oral surgery; 3) Optometry; and 4) Podiatry.

Include one physician representative of each of the following clinical specialties and sub-specialties:

- Allergy;
- Anesthesia;
- Cardiology;
- Cardiovascular/Thoracic Surgery;
- Dermatology;
- Emergency Medicine;
- Family Practice;
- Gastroenterology;
- Gerontology
- General Surgery;
- Hematology;
- Internal Medicine;
- Infectious Disease;
- Interventional Pain Management;
- Medical Oncology;
- Nephrology;
- Neurology;
- Neurosurgery;
- Nuclear Medicine;
- Obstetrics/Gynecology;
- Ophthalmology;
- Orthopedic Surgery;
- Otolaryngology;
- Pathology;
- Pediatrics;
- Peripheral Vascular Surgery;
- Physical Medicine and Rehabilitation;
- Plastic and Reconstructive Surgery;
- Psychiatry;

- Pulmonary Medicine;
- Radiation Oncology;
- Radiology;
- Rheumatology; and
- Urology

The CMD must work with the societies to ensure that committee members are representative of the entire service area and represent a variety of practice settings.

Exhibit 29 – Reserve for Future Use

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