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Introduction

This chapter has important information about filing claims to the DME MAC. Most Medicare suppliers are required to bill claims electronically (rather than paper) in accordance with the Administrative Simplification Compliance Act (ASCA). If you do meet one of the ASCA exceptions, as detailed in this chapter, then the information in this chapter should serve as your primary source of guidance regarding how to submit paper claims to the DME MAC. The information contained in the claim completion instructions below is also valuable for suppliers who are billing claims electronically. All suppliers should be familiar with the rules and guidance of this chapter. For information about filing claims electronically, see Chapter 8 of this manual and the Common Electronic Data Interchange (CEDI) website at https://www.ngscedi.com/ for loops and segments guidance.

Before billing a claim to the DME MAC, you must obtain a National Provider Identifier (NPI) and register with the National Provider Enrollment (NPE) contractors. See Chapter 2 of this manual for information about obtaining an NPI and registering with the NPE Contractor.

NOTE: For claims with dates of service on or after January 1, 2023, you no longer need to submit CMNs or DIFs with claims. Due to electronic filing requirements, claims received with these forms attached will be rejected and returned.

For claims with dates of service prior to January 1, 2023, if a CMN or DIF is required, it must be submitted with the claim or be on file with a previous claim.

1. Mandatory Claim Filing

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 1, §30.3.9

In many situations, claim filing is mandatory. The rules below outline the CMS claims filing policy.

The Centers for Medicare & Medicaid Services (CMS) Claims Filing Policy

- For services furnished on or after September 1, 1990, physicians and suppliers must complete and submit both assigned and nonassigned Part B claims for beneficiaries.
- The claims filing requirement applies to all suppliers who provide covered services to Medicare beneficiaries.
- You are not required to take assignment of Medicare benefits unless you are enrolled in the Medicare Participating Supplier Program or except where CMS regulations require mandatory assignment (i.e., Medicare covered drugs, etc.).
- You may not charge the beneficiary for preparing and filing a Medicare claim. The beneficiary may also not be charged for the completion of a Certificate of Medical Necessity (CMN) form.
- The DME MAC will monitor supplier compliance with the Medicare claims filing requirement.
- Suppliers who do not submit Medicare claims for Medicare beneficiaries may be subject to a civil monetary penalty of up to $2,000 for each violation.
- Medicare claims must be filed within one year from the service date (see “Time Limit for Filing Claims” below).
- The Administrative Simplification Compliance Act (ASCA) mandates the submission of electronic claims to Medicare unless you meet certain “exceptions” described within the law (see below for more information about ASCA).
- If an ASCA exception is met, a Medicare paper claim must be submitted on the Health Insurance Claim Form [CMS-1500 (02/12)]. No superbills can be accepted.
- If you determine that the beneficiary has other insurance which may pay primary to Medicare, you may file a claim with the primary insurer on the beneficiary's behalf; however, you are not required by law to submit claims to other payers. If you receive a determination on the claim directly from the primary payer, you are responsible for submitting a claim to Medicare for secondary payment. If the beneficiary files a claim to the primary insurer, he/she may forward the primary payer information to you to submit the Medicare Secondary Payer (MSP) claim. You must submit the secondary claim to Medicare for the beneficiary in accordance with the mandatory claims filing requirements.

Mandatory Claim Filing Does Not Affect the Following:

- Supplier/Beneficiary Payment Arrangements - Suppliers who do not accept assignment may continue to request payment in full at the time that the service is provided if the claim for this service is unassigned. We encourage you to file the claims about the same time you request payment. This will reduce a potential financial hardship for the beneficiary and reduce future inquiries you may receive regarding the status of the claim.
- Providing Suppliers Information on Non-Assigned Claims - By not accepting assignment of Medicare benefits, suppliers are not a party to the Medicare payment transaction between

Medicare and the Medicare beneficiary. The transaction is covered by the Privacy Act. Our office can only give limited information on non-assigned claims. The DME MAC cannot disclose payment amounts.

- Statutorily-Excluded Medicare Services - Suppliers are not required to file claims on behalf of Medicare beneficiaries for items that do not have a covered Medicare benefit or for other health insurance benefits. However, if the beneficiary (or his/her representative) believes that a service may be covered or desires a formal Medicare determination, you must file a claim for that service to effectuate the beneficiary's right to a determination. You should note on the claim your belief that the service is noncovered and that it is being submitted at the beneficiary's insistence. The documentation should state the beneficiary-specific reason why you consider the item to be noncovered, and the modifier GY should be appended to the HCPCS code(s) on the claim. Use of this modifier does not generate an automatic denial of the service. Coverage decisions are made based on the item billed and other pertinent information on the claim without regard to the presence or absence of this modifier.

2. Assignment Agreement

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 1, §30.3.2
Medicare DMEPOS Supplier Participation Agreement – CMS 460

An assignment agreement is between a supplier of services and a Medicare beneficiary. The option of accepting assignment belongs solely to the supplier. Participating suppliers have signed a contract agreeing to accept assignment on all services rendered to Medicare beneficiaries. Nonparticipating suppliers have the option of accepting assignment on a claim-by-claim basis except where CMS regulations require mandatory assignment (i.e., Medicare covered drugs, etc.).

When you accept assignment, you are bound by law to accept the DME MAC's determination of the approved amount as the full fee for the service rendered. You may not bill, or accept payment for, the amount of the reduced charges; however, an attempt must be made to collect (1) twenty percent of the approved charge (coinsurance), (2) any amount applied to the deductible and (3) any noncovered charges subject to the Limitation of Liability provisions.

Example of Assigned Claim:

Submitted fee	$25.00
Approved charge (paid at 80% assuming that the annual deductible has been met)	$20.00
Allowable charge reduction which cannot be collected from any source (submitted fee minus approved charge)	$5.00
Payment (80% of the approved charge)	$16.00
Coinsurance (20% of approved charge)	$4.00

If you repeatedly violate the assignment agreement, you could be charged and found guilty of a misdemeanor, punishable by a maximum fine of $2,000, up to six months imprisonment, or both.

Mandatory Assignment for Covered Drugs Billed to Medicare

Section 114 of the Benefits Improvement and Protection Act of 2000 (BIPA) states, in part, "Payment for a charge for any drug or biological for which payment may be made under this part may be made only on an assignment-related basis." Mandatory assignment applies only to those drugs "for which payment may be made" – i.e., Medicare-covered drugs. Drugs that would never be paid (e.g., no benefit category, never medically necessary) are not subject to mandatory assignment.

You may not render a charge or bill to anyone for these drugs and biologicals for any amount other than the Medicare Part B deductible and coinsurance.

If you submit an unassigned claim for a drug or biological, the DME MAC will process the claim as though you accepted assignment.

If the beneficiary already paid for the billed services, enter the amount paid for covered services, coinsurance, and deductible in block 29 of the CMS-1500 claim form.

The DME MAC will reimburse the beneficiary any amount they paid over the patient responsibility amount shown on the Medicare Remittance Advice (RA). You must issue the beneficiary a refund within 30 days of the date of the RA for the difference between the beneficiary's payment to you and the total of the amount shown as the patient responsibility and as paid to the beneficiary on the RA. See Chapter 17 of this manual for more information about RAs.

3. Administrative Simplification Compliance Act (ASCA)

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 24, §90

Section 3 of the Administrative Simplification Compliance Act (ASCA), Public Law (PL) 107-105, and the implementing regulation at 42 CFR 424.32, requires that **all initial claims** for reimbursement under Medicare (except from small providers) be submitted electronically as of October 16, 2003, with limited exceptions. Initial claims are those claims submitted to a MAC for the first time, including:

- Resubmitted previously rejected claims
- Claims with paper attachments
- Demand claims
- Claims where Medicare is secondary and there is only one primary payer
- Nonpayment claims

Further, ASCA amendment to Section 1862(a) of the Act prescribes that “no payment may be made under Part A or Part B of the Medicare Program for any expenses incurred for items or services” for which a claim is submitted in a non-electronic form. Consequently, unless you fit one of the exceptions listed below, any paper claims that you submit to Medicare will not be paid. In addition, if it is determined that you are in violation of the statute or rule, you may be subject to claim denials, overpayment recoveries, and applicable interest on overpayments.

Medicare will not cover claims submitted on paper unless they meet the limited exception criteria. Claims denied for this reason will contain claim adjustment reason code 96 (Noncovered charge[s]) and remark code M117 (Not covered unless submitted via electronic claim). See Chapter 17 of this manual for information about claim reason and remark codes.

Exceptions to Electronic Claim Submission

There are some exceptions to the electronic claim submission requirement that allow suppliers to continue to bill paper claims. The exceptions include the following:

1. You are a small provider. To qualify as a small provider, DMEPOS suppliers must have fewer than 10 full time employees (FTEs). A small provider can elect to submit all, some, or none of their claims electronically;

2. Dental Claims;

3. Claims submitted by participants in a Medicare demonstration project for services or items covered under that demonstration project when paper claim filing is required as result of the inability of the HIPAA claim implementation guide to handle data essential for that demonstration;

4. Roster claims for mass immunizations, such as flu or pneumonia injections—Paper roster bills cover multiple beneficiaries on the same claim. This exception applies to providers who do not have an agreement in place with a Medicare contractor that commits them to electronic submission of mass immunization claims;

5. Claims sent to Medicare when more than one other insurer was liable for payment prior to Medicare;

6. Claims submitted by providers that rarely treat Medicare patients and that submit fewer than 10 claims a month to Medicare in total (total of all claims sent to all Medicare contractors including the Railroad Medicare Carrier);

7. Home oxygen therapy claims for which the CR5 segment is required in an X12 837 version 4010A1 claim but for which the requirement notes in either CR513, CR514 and/or CR515 do not apply, e.g., oxygen saturation is not greater than 88%, arterial PO2 is more than 60 mmHg;

8. Claims submitted by beneficiaries;

9. Claims from providers that only furnish services outside of the United States;

10. Claims from providers experiencing a disruption in their electricity or communication connection that is outside of their control and is expected to last longer than two days. This exception applies only while electricity or electronic communication is disrupted; and

11. Providers that can establish that some other “unusual circumstance” exists that precludes submission of claims electronically.

The process for post-payment based enforcement is as follows:

- The DME MAC will analyze reports displaying the number of paper claims that all suppliers submitted each quarter.

- By the end of the month following the quarter, selected suppliers who have submitted the highest numbers of paper claims will be reviewed.

- The DME MAC will ask these suppliers to provide information that establishes the exception criteria listed above.

If you, as one such supplier, do not respond to this initial “Request for Documentation” letter within 45 days of receipt, the DME MAC will notify you by mail that Medicare will deny and not pay any paper claims that you submit beginning ninety days after the date of the initial request letter. If you do respond to this initial letter but your response does not establish eligibility to submit paper claims, the DME MAC will notify you by mail of your ineligibility to submit paper claims. This Medicare decision is not subject to appeal.

In these letters, the DME MAC will also tell you how to obtain free and commercially available HIPAA-compliant billing software packages (also see Chapter 8 of this manual).

If you respond with information that does establish eligibility to submit paper claims, the DME MAC will notify you by mail that you meet one or more exception criteria to the requirements in Section 3 of the ASCA, Pub.L.107-105 (ASCA), and the implementing regulation at 42 CFR 424.32, and you will be permitted to submit paper claims. However, you will be cautioned that if your situation changes to the point that you no longer meet the exception criteria, you will be required to begin electronic submission of your claims.

If you are permitted to submit paper claims, the DME MAC will not review your eligibility to submit paper claims again for at least two years.

4. CMS-1500 Claim Form

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 26, §10

The CMS-1500 claim form answers the needs of many health insurers. It is the basic form prescribed by CMS for Medicare claims from suppliers. It has also been adopted by CHAMPUS/TRICARE and has received the approval of the American Medical Association (AMA) Council on Medical Services. The CMS-1500 form is the prescribed form for claims prepared and submitted by physicians or suppliers, whether or not the claims are assigned.

The White House Office of Management and Budget (OMB) recently approved a revised version of the CMS-1500 form, version 02/12. All claims received on and after April 1, 2014, must be submitted on the current version 02/12 form. Claims using any previous versions of the CMS-1500 form will not be accepted.

Instructions for completing the CMS-1500 claim form are provided in this chapter. Instructions are also available in Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 26 (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c26.pdf).

Ordering the Form

You are responsible for purchasing your own CMS-1500 forms. In order to purchase claim forms, contact the U.S. Government Printing Office at 1.866.512.1800, local printing companies in your area, and/or office supply stores. The form can be obtained from any printer or printed in-house as long as they follow the CMS approved specifications developed by the American Medical Association. Photocopies of the CMS-1500 form are NOT acceptable. Medicare accepts any type of the form (i.e., single sheet, snap-out, continuous feed, etc.) for processing.

5. Guidelines for Filing Paper Claims

*** Failure to follow these guidelines could cause a delay in processing, denial of the claim, or the accuracy of payment. ***

The Administrative Simplification Compliance Act (ASCA) mandates the submission of electronic claims to Medicare unless you meet certain “exceptions” described within the law. If you believe you meet the exception criteria and will be submitting your claims on paper, please adhere to the following guidelines.

1. Do not submit black CMS-1500 forms. This includes submitting copies or carbon copies. Always submit a RED CMS-1500 form.
2. Do not write or stamp information in red ink. Information in red will not show up on the image and will not be available during processing.
3. Do not use light print or a dot matrix printer which causes broken lines. Check to make sure the ink is dark. Laser or inkjet printers are preferred.
4. Do not use small font type and size. For best processing results we recommend font type Lucida Console and size 10.
5. Do not use handwriting. It may be too light or simply unrecognizable.
6. Do not highlight items on the CMS-1500 form or attachments. This will cause the claim to be illegible which slows down the processing of the claim and may cause processing errors.
7. Do not use stamps or stickers within the body of the claim. If you must use a stamp or sticker, put it at the top of the claim within the blank area.
8. Do not leave block 11 blank. If no primary insurance exists, enter “NONE” in the field.
9. Do not use extra verbiage within the body of the claim. If you must put extra verbiage on the claim, use block 19 or an attachment.
10. Do not put a description next to the diagnosis code in block 21. All that is needed is the ICD-10 alpha/numeric diagnosis code.
11. Do not submit more than 12 diagnosis codes within block 21.
12. Do not submit more than one diagnosis pointer in block 24e. Only the first pointer will be used for processing.
13. Do not submit more than six service lines within block 24.
14. Do not put a description of the HCPCS procedure codes or times/units underneath the line item in blocks 24a – 24j. It is not needed and may cause processing errors.
15. Do not place the number of units/days in block 24g too close to the charges in 24f. This may cause the units/days to be read as a part of the submitted charges and the number of units/days to default to 1. Right justifying the days/units in block 24g will give more space between the two fields.
16. The supplier signature in block 31 must be that of an individual, not a company name.

17. Do not put a phone number on the first line of block 33. Submit the phone number below your name and address.
18. Do not omit the zip code in block 33. This block is used as the mailing address when a claim is returned.
19. Do not change the size of EOBs or copy them across to two pages. This may cause your EOB to be illegible.
20. Submit claims to PO Box 20013, Nashville, TN 37202 only.

6. Claim Completion Instructions

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 26

Responsibility for Accurate Claims

You are ultimately responsible for the accuracy of claims filed for your services. We recommend that your office set a policy to ensure that all necessary information is included on the initial claim submission and that the information is correct. Please refer to the Claim Completion Instructions below for guidance on completing the claim form.

Health Insurance Claim Form CMS-1500

The Form CMS-1500 (Health Insurance Claim Form) is sometimes referred to as the AMA (American Medical Association) form. The Form CMS-1500 is the prescribed form for claims prepared and submitted by physicians or suppliers (except for ambulance suppliers), whether or not the claims are assigned.

A sample of the CMS-1500 can be found at https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS1500.pdf.

Legend Description

MM Month (e.g., December = 12)

DD Day (e.g., Dec 15 = 15)

YY 2 position Year (e.g., 1998 = 98)

CCYY 4 position Year (e.g., 1998 = 1998)

(MM | DD | YY) or (MM | DD | CCYY) – A space must be reported between month, day, and year (e.g., 12 | 15 | 98 or 12 | 15 |1998). This space is delineated by a dotted vertical line on the Form CMS-1500.

(**MMDDYY) or (MMDDCCYY)** – No space may be reported between month, day, and year (e.g., 121598 or 12151998). The date must be recorded as one continuous number.

Claims that are Incomplete or Contain Invalid Information

If a claim is submitted with incomplete or invalid information, it will be returned to the submitter as unprocessable.

Items 1-13 – Patient and Insured Information

Item 1 – Show the type of health insurance coverage applicable to this claim by checking the appropriate box. For Medicare claims, check “Medicare.”

Item 1a – Enter the patient’s Medicare Beneficiary Identifier (MBI) whether Medicare is the primary or secondary payer. This is a required field.

Item 2 – Enter the patient’s last name, first name, and middle initial (if any) as shown on the patient’s Medicare card. This is a required field.

Item 3 – Enter the patient’s 8-digit birth date (MM | DD | CCYY) and sex.

Item 4 – If there is insurance primary to Medicare, either through the patient’s or spouse's employment or any other source, list the name of the insured here. When the insured and the patient are the same, enter the word SAME. If Medicare is primary, leave blank.

Item 5 – Enter the patient’s mailing address and telephone number. On the first line enter the street address; the second line, the city and state; the third line, the ZIP code and phone number.

Item 6 – Check the appropriate box for patient’s relationship to insured when item 4 is completed.

Item 7 – Enter the insured's address and telephone number. When the address is the same as the patient’s, enter the word SAME. Complete this item only when items 4, 6, and 11 are completed.

Item 8 –Leave blank.

Item 9 – Enter the last name, first name, and middle initial of the enrollee in a **Medigap** policy if it is different from that shown in item 2. Otherwise, enter the word SAME. If no Medigap benefits are assigned, leave item 9 blank.

NOTE: Only participating physicians and suppliers are to complete item 9 and its subdivisions and only when the beneficiary wishes to assign his/her benefits under a MEDIGAP policy to the Participating Physician or Supplier. Participating physicians and suppliers must enter information required in item 9 and its subdivisions if requested by the beneficiary. Participating physicians/suppliers sign an agreement with Medicare to accept assignment of Medicare benefits for **all** Medicare patients. A claim for which a beneficiary elects to assign his/her benefits under a Medigap policy to a participating physician/supplier is called a mandated Medigap transfer.

Medigap – Medigap policy meets the statutory definition of a "Medicare supplemental policy" contained in §1882(g)(1) of title XVIII of the Social Security Act (the Act) and the definition contained in the NAIC Model Regulation that is incorporated by reference to the statute. It is a health insurance policy or other health benefit plan offered by a private entity to those persons entitled to Medicare benefits and is specifically designed to supplement Medicare benefits. It fills in some of the "gaps" in Medicare coverage by providing payment for some of the charges for which Medicare does not have responsibility due to the applicability of deductibles, coinsurance amounts, or other limitations imposed by Medicare. It does not include limited benefit coverage available to Medicare beneficiaries such as "specified disease" or "hospital indemnity" coverage.

Also, it explicitly excludes a policy or plan offered by an employer to employees or former employees, as well as that offered by a labor organization to members or former members.

Do not list other supplemental coverage in item 9 and its subdivisions at the time a Medicare claim is filed. Other supplemental claims are forwarded automatically to the private insurer if the private insurer contracts with the Coordination of Benefits Contractor (COBC) to send Medicare claim

information electronically. If there is no such contract, the beneficiary must file his/her own supplemental claim. See Chapter 7 of this manual for more information about supplemental insurance.

If the beneficiary wants Medicare payment data forwarded to a Medigap insurer through the Medigap claim-based crossover process, you must (if you are participating) accurately complete all of the information in items 9, 9a, and 9d. Otherwise, the DME MAC cannot forward the claim information to the Medigap insurer.

Item 9a – Enter the policy and/or group number of the Medigap insured preceded by MEDIGAP, MG, or MGAP.

NOTE: Item 9d must be completed if the provider enters a policy and/or group number in item 9a.

Item 9b – Leave blank.

Item 9c – Leave blank if item 9d is completed. Otherwise, enter the claims processing address of the Medigap insurer. Use an abbreviated street address, two-letter postal code, and ZIP code copied from the Medigap insured's Medigap identification card. Example: "1257 Anywhere St. MD 21204"

Item 9d – Enter the Medigap COBA ID number of the Medigap insurer.

When seeking to have the beneficiary's claim crossed over to a Medigap insurer, you must only enter the COBA Medigap claim-based ID within item 9d. If you enter the PAYERID of the Medigap insurer program or its plan name within item 9d, the DME MAC will be unable to forward the claim information to the Coordination of Benefits Contractor (COBC) for transfer to the Medicare insurer.

NOTE: Claim-based Medigap COBA ID numbers are 5-digit numbers in the range 55000-59999 and are assigned by the COBC. A list of Medigap companies and their corresponding COBA ID numbers is available on the CMS website at: https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/COBA-Trading-Partners/Coordination-of-Benefits-Agreements/Coordination-of-Benefits-Agreement-page.html.

Items 10a through 10c – Check "YES" or "NO" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in item 24. Enter the state postal code. Any item checked "YES" indicates there may be other insurance primary to Medicare. Identify primary insurance information in item 11.

Item 10d – Use this item exclusively for Medicaid (MCD) information. If the patient is entitled to Medicaid, enter patient's Medicaid number preceded by 'MCD'.

Item 11 – **THIS ITEM MUST BE COMPLETED**; it is a required field. By completing this item, you acknowledge having made a good faith effort to determine whether Medicare is the primary or secondary payer.

If there is insurance primary to Medicare, enter the insured's policy or group number and proceed to items 11a - 11c. Items 4, 6, and 7 must also be completed.

NOTE: Enter the appropriate information in item 11c if insurance primary to Medicare is indicated in item 11. If there is no insurance primary to Medicare, enter the word "NONE" and proceed to item 12. If the insured reports a terminating event with regard to insurance which had been primary to Medicare (e.g., insured retired), enter the word "NONE" and proceed to item 11b.

Insurance Primary to Medicare – Circumstances under which Medicare payment may be secondary to other insurance include:

- Group Health Plan Coverage
    - Working Aged
    - Disability (Large Group Health Plan)
    - End Stage Renal Disease
- No Fault and/or Other Liability
- Work-Related Illness/Injury
    - Workers' Compensation
    - Black Lung
    - Veterans Benefits

NOTE: For a paper claim to be considered for Medicare secondary payer (MSP) benefits, a copy of the primary payer's explanation of benefits (EOB) notice must be forwarded along with the claim form.

See Chapter 11 of this manual for more information about MSP.

Item 11a – Enter the insured's 8-digit birth date (MM | DD | CCYY) and sex if different from item 3.

Item 11b – Enter employer's name, if applicable. If there is a change in the insured's insurance status (e.g., retired), enter either a 6-digit (MM | DD | YY) or 8-digit (MM | DD | CCYY) retirement date preceded by the word "RETIRED."

Item 11c – Enter the 9-digit PAYERID number of the primary insurer. If no PAYERID number exists, then enter the **complete** primary payer's program or plan name. If the primary payer's EOB does not contain the claims processing address, record the primary payer's claims processing address directly on the EOB. This is required if there is insurance primary to Medicare that is indicated in item 11.

Item 11d – Leave blank. Not required by Medicare.

Item 12 – The patient or authorized representative must sign and enter either a 6-digit date (MM | DD | YY), 8-digit date (MM | DD | CCYY), or an alpha-numeric date (e.g., January 1, 1998) unless the signature is on file. In lieu of signing the claim, the patient may sign a statement to be retained in the provider, physician, or supplier file. If the patient is physically or mentally unable to sign, a representative may sign on the patient's behalf. In this event, the statement's signature line must indicate the patient's name followed by “by” the representative's name, address, relationship to the patient, and the reason the patient cannot sign. The authorization is effective indefinitely unless the patient or the patient's representative revokes this arrangement.

NOTE: This can be "Signature on File" and/or a computer generated signature. The patient's signature authorizes release of medical information necessary to process the claim. It also authorizes payment of benefits to the provider of service or supplier when the provider of service or supplier accepts assignment on the claim.

Signature by Mark (X) – When an illiterate or physically handicapped enrollee signs by mark, a witness must enter his/her name and address next to the mark.

Item 13 – The patient's signature or the statement "signature on file" in this item authorizes payment of medical benefits to you. The patient or his/her authorized representative signs this item or the signature must be on file separately with you as an authorization. However, note that when payment can only be made on an assignment-related basis or when payment is for services furnished by a participating supplier, a patient's signature or a "signature on file' is not required in order for Medicare payment to be made directly to you.

The presence of or lack of a signature or "signature on file" in this field will be indicated as such to any downstream coordination of benefits trading partners (supplemental insurers) with whom CMS has a payer-to-payer coordination of benefits relationship. Medicare has no control over how supplemental claims are processed, so it is important that you accurately address this field as it may or may not affect supplemental payments to you and/or your patients.

In addition, the signature in this item authorizes payment of mandated Medigap benefits to the participating supplier if required Medigap information is included in item 9 and its subdivisions. The patient or his/her authorized representative must sign this item or the signature must be on file as a separate Medigap authorization. The Medigap assignment on file in the participating supplier's office must be insurer specific. It may state that the authorization applies to all occasions of service until it is revoked.

NOTE: This can be "Signature on File" signature and/or a computer generated signature.

Items 14-33 - Provider of Service or Supplier Information

Reminder: For date fields other than date of birth, all fields shall be one or the other format, 6-digit: (MM | DD | YY) or 8-digit: (MM | DD | CCYY). Intermixing the two formats on the claim is not allowed.

Item 14 – Leave blank. Not required by the DME MAC.

Item 15 – Leave blank. Not required by Medicare.

Item 16 – Leave blank. Not required by the DME MAC.

Item 17 – Enter the name of the referring or ordering physician if the service or item was ordered or referred by a physician. All physicians who order services or refer Medicare beneficiaries must report this data. When a claim involves multiple referring and/or ordering physicians, a separate Form CMS-1500 shall be used for each ordering/referring physician.

Additionally enter one of the following qualifiers as appropriate to identify the role that this physician (or non-physician practitioner) is performing:

Qualifier	Provider Role
DN	Referring Provider
DK	Ordering Provider
DQ	Supervising Provider

Enter the qualifier to the left of the dotted vertical line on item 17.

The term "physician" when used within the meaning of §1861(r) of the Act and used in connection with performing any function or action refers to:

1. A doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he/she performs such function or action;

2. A doctor of dental surgery or dental medicine who is legally authorized to practice dentistry by the State in which he/she performs such functions and who is acting within the scope of his/her license when performing such functions;

3. A doctor of podiatric medicine for purposes of §§(k), (m), (p)(1), and (s) and §§1814(a), 1832(a)(2)(F)(ii), and 1835 of the Act, but only with respect to functions which he/she is legally authorized to perform as such by the State in which he/she performs them;

4. A doctor of optometry, but only with respect to the provision of items or services described in §1861(s) of the Act which he/she is legally authorized to perform as a doctor of optometry by the State in which he/she performs them; or

5. A chiropractor who is licensed as such by a State (or in a State which does not license chiropractors as such), and is legally authorized to perform the services of a chiropractor in the jurisdiction in which he/she performs such services, and who meets uniform minimum standards specified by the Secretary, but only for purposes of §§1861(s)(1) and 1861(s)(2)(A) of the Act, and only with respect to treatment by means of manual manipulation of the spine (to correct a subluxation). For the purposes of §1862(a)(4) of the Act and subject to the limitations and conditions provided above, chiropractor includes a doctor of one of the arts specified in the statute and legally authorized to practice such art in the country in which the inpatient hospital services (referred to in §1862(a)(4) of the Act) are furnished.

Referring physician - is a physician who requests an item or service for the beneficiary for which payment may be made under the Medicare program.

Ordering physician - is a physician or, when appropriate, a non-physician practitioner who orders non-physician services for the patient. Examples of services that might be ordered include diagnostic laboratory tests, clinical laboratory tests, pharmaceutical services, durable medical equipment, and services incident to that physician’s or non-physician practitioner’s service.

The ordering/referring requirement became effective January 1, 1992, and is required by §1833(q) of the Act. **All claims** for Medicare covered services and items that are the result of a physician's order or referral shall include the ordering/referring physician's name. See item 17b below for further guidance on reporting the referring/ordering provider’s NPI.

Item 17a – Leave Blank (effective May 23, 2008, **17a is not to be reported**, but 17b MUST be reported when a service was ordered or referred by a physician)

Item 17b – Enter the NPI of the referring/ordering physician listed in item 17. All physicians who order services or refer Medicare beneficiaries must report this data.

Item 18 – Leave blank. Not required by the DME MAC.

Item 19 – Enter additional information that may be needed for claim processing. Below are several instances when item 19 may be required for DMEPOS claims (this list is not all-inclusive).

- Enter the drug's name and dosage when submitting a claim for Not Otherwise Classified (NOC) drugs.

- Enter a concise description of an "unlisted procedure code" or an NOC code if one can be given within the confines of this box. Otherwise an attachment shall be submitted with the claim.

- Enter all applicable modifiers when modifier -99 (multiple modifiers) is entered in item 24d. If modifier -99 is entered on multiple line items of a single claim form, all applicable modifiers for each line item containing a -99 modifier should be listed as follows: 1=(mod), where the number 1 represents the line item and "mod" represents all modifiers applicable to the referenced line item.

- Enter the statement, "Patient refuses to assign benefits" when the beneficiary absolutely refuses to assign benefits to a *non-participating physician/supplier who accepts assignment on a claim.* In this case, *payment can only be made directly to the beneficiary.*

- Method II suppliers shall enter the most current HCT value for the injection of Aranesp for ESRD beneficiaries on dialysis. (See Pub. 100-04, Chapter 8, Section 60.7.2.)

Item 20 – Leave blank. Not required by the DME MAC.

Item 21 – Enter the patient's diagnosis/condition. You must use an ICD-10 code number and code to the highest level of specificity for the date of service. Enter up to 12 diagnoses in priority order. All narrative diagnoses for non-physician specialties must be submitted on an attachment.

Item 21 ICD Ind. – Enter “0” or leave blank. Currently not required by Medicare.

Item 22 – Leave blank. Not required by Medicare.

Item 23 – Enter the Quality Improvement Organization (QIO) prior authorization number for those procedures requiring QIO prior approval.

Note: For DME MACs this would be the Unique Tracking Number of a Prior Authorization number for DMEPOS items requiring prior approval.

Item 24 – The six service lines in section 24 have been divided horizontally to accommodate submission of supplemental information to support the billed service. The top portion in each of the six service lines is shaded and is the location for reporting supplemental information. It is not intended to allow the billing of 12 service lines.

When required to submit NDC drug and quantity information for Medicaid rebates, submit the NDC code in the red shaded portion of the detail line item in positions 01 through position 13. The NDC is to be preceded with the qualifier N4 and followed immediately by the 11-digit NDC code (e.g. N499999999999). Report the NDC quantity in positions 17 through 24 of the same red shaded portion. The quantity is to be preceded by the appropriate qualifier: UN (units), F2 (international units), GR (gram) or ML (milliliter). There are six bytes available for quantity. If the quantity is less than six bytes, left justify and space-fill the remaining positions (e.g. UN2 or F2999999).

At this time, the shaded area in 24a through 24h is not used by Medicare. Future guidance will be provided on when and how to use this shaded area for the submission of Medicare claims.

Item 24A – Enter a 6-digit (MMDDYY) or 8-digit (MMDDCCYY) date for each procedure, service, or supply. When "from" and "to" dates are shown for a series of identical services, enter the number of days or units in column G. This is a required field.

Item 24B – Enter the appropriate place of service code(s). Identify the location, using a place of service code, for each item used or service performed. This is a required field. (See the “Place of Service” section below for additional information.)

NOTE: For DMEPOS claims, the place of service is considered to be the place where the beneficiary will primarily use the DMEPOS item.

Item 24C – Medicare providers are not required to complete this item.

Item 24D – Enter the procedures, services, or supplies using the CMS Healthcare Common Procedure Coding System (HCPCS) code. When applicable, show HCPCS code modifiers with the HCPCS code. The Form CMS-1500 (02-12) has the ability to capture up to four modifiers. If more than four modifiers are needed, use modifier 99 (overflow) as the fourth modifier and enter the additional modifiers in item 19.

Enter the specific procedure code without a narrative description. However, when reporting an "unlisted procedure code" or a "not otherwise classified" (NOC) code, include a narrative description in item 19 if a coherent description can be given within the confines of that box. Otherwise, an attachment must be submitted with the claim. If an "unlisted procedure code" or an NOC code is indicated in item 24d, but an accompanying narrative is not present in item 19 or on an attachment, the claim will be returned as unprocessable.

This is a required field.

Item 24E – Enter the diagnosis code reference number as shown in item 21 to relate the date of service and the items or services rendered to the primary diagnosis. Enter only one reference number per line item. When multiple items or services are rendered, enter the primary reference number for each service, either a 1, a 2, a 3, or a 4. This is a required field.

If a situation arises where two or more diagnoses are required for a procedure code, reference only one of the diagnoses in item 21.

Item 24F – Enter the charge for each listed service.

Note for electronic claim submissions: The maximum number of characters that can be submitted in any dollar amount field is seven characters. Claims containing a dollar amount in excess of $99,999.99 will be rejected. If the claim total exceeds $99,999.99, bill the lines on separate claims so that the total of any one claim does not exceed $99,999.99. If one line exceeds $99,999.99, but represents multiple services, split the line and bill on separate claims so that the total of any one claim does not exceed $99,999.99.

For more information regarding electronic claim submission, refer to https://www.cgsmedicare.com/jb/claims/edi.html.

Item 24G – Enter the number of days or units. If only one service is performed, the numeral 1 must be entered.

Some services require that the actual number or quantity billed be clearly indicated on the claim form (e.g., multiple ostomy or urinary supplies). When multiple items or services are provided, enter the actual number provided.

NOTE: This field should contain at least one day or unit. The DME MAC will default to "1" unit when the information in this field is missing to avoid returning as unprocessable.

Item 24H – Leave blank. Not required by Medicare.

Item 24I – Leave blank. Not required by the DME MAC.

Item 24J – Enter your NPI number in the lower unshaded portion.

NOTE: Effective May 23, 2008, the shaded portion of 24J is not to be reported.

Item 25 – Enter your Federal Tax ID (Employer Identification Number or Social Security Number) and check the appropriate check box. You are not required to complete this item for crossover purposes since the DME MAC will retrieve the tax identification information from their internal provider file for inclusion on the COB outbound claim. However, tax identification information is used in the determination of accurate National Provider Identifier reimbursement. Reimbursement of claims submitted without tax identification information will/may be delayed.

Item 26 – Enter the patient's account number assigned by your accounting system. This field is optional to assist you in patient identification. As a service, any account numbers entered here will be returned to you.

Item 27 – Check the appropriate block to indicate whether you accept assignment of Medicare benefits. If Medigap is indicated in item 9 and Medigap payment authorization is given in item 13, you must also be a Medicare participating supplier and accept assignment of Medicare benefits for all covered charges for all patients.

The following providers of service/suppliers and claims can only be paid on an assignment basis (the services applicable to DME MAC are **bolded**):

- Clinical diagnostic laboratory services;
- Physician services to individuals dually entitled to Medicare and Medicaid;
- **Participating physician/supplier services;**
- Services of physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives, certified registered nurse anesthetists, clinical psychologists, and clinical social workers;
- Ambulatory surgical center services for covered ASC procedures;
- Home dialysis supplies and equipment paid under Method II;
- Ambulance services;
- **Drugs and biologicals;** and
- Simplified Billing Roster for influenza virus vaccine and pneumococcal vaccine.

Item 28 – Enter total charges for the services (i.e., total of all charges in item 24f).

Item 29 – Enter the total amount the patient paid on the **covered services only**.

NOTE: This field may/will affect payment if assignment was accepted.

Item 30 – Leave blank. Not required by Medicare.

Item 31 – Enter your signature (or that of your authorized representative) and either the 6-digit date (MM | DD | YY), 8-digit date (MM | DD | CCYY), or alphanumeric date (e.g., January 1, 1998) the form was signed.

NOTE: This is a required field; however, the claim can be processed if the following is true: If a physician, supplier, or authorized person's signature is missing, but the signature is on file; or if any authorization is attached to the claim, or if the signature field has "Signature on File" and/or a computer-generated signature.

Item 32 – For durable medical equipment, orthotic, and prosthetic claims, the name and address of the location where the order was accepted must be entered (DME MAC only). This field is required. When more than one supplier is used, a separate CMS-1500 claim form shall be used to bill for each supplier. This item is completed whether the supplier's personnel performs the work at the physician's office or at another location.

For foreign claims, only the enrollee can file for Part B benefits rendered outside of the United States.

Item 32a – If required by Medicare claims processing policy, enter the NPI of the service facility

Item 32b – Effective May 23, 2008, Item 32b is not to be reported.

Item 33 – Enter your billing name, address, ZIP code, and telephone number. This is a required field.

Item 33a – Enter your NPI. This is a required field.

Item 33b – Effective May 23, 2008, Item 33b is not to be reported (unless billed via Indirect Payment Procedure (IPP); if you are an IPP biller, please follow IPP billing guidelines).

Supplier Signature Requirements (CMS-1500, Item 31)

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 1, §50.1.6(B)

The rules below apply to both assigned and unassigned claims.

To fulfill the signature requirement of item 31 of the Form CMS-1500, you may:

a) Sign item 31 of Form CMS-1500.

b) Sign a one time certification letter for machine-prepared claims submitted on other than paper vehicles.

c) Authorize an employee (e.g., nurse, administrative assistant) to enter the supplier signature in item 31 of the Form CMS-1500 (manually, by stamp-facsimile or block letters, or by computer).

d) Authorize a non-employee agent (e.g., billing service or association) to enter the supplier signature in item 31 of the Form CMS-1500, followed by the agent’s name, title, and organization (e.g., a billing agent might enter by stamp “Dr. Tom Jones by Robert Smith, Secretary, Ajax Billing Service”). Alternatively, the agent may simply enter the supplier signature.

Beneficiary Signature Requirements (CMS-1500, Items 12 & 13)

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 1, §50.1.6(A)

A request for payment signed by the beneficiary must be filed on or with each claim for charge basis reimbursement except as provided below. All rules apply to both assigned and unassigned claims unless otherwise indicated.

1. No beneficiary signature is required when:

    a) An unassigned claim is submitted by a public welfare agency on a bill which is paid.

    b) The beneficiary is deceased, the bill is unpaid, and you agree to accept the Medicare approved amount as the full charge.

2. A signature by mark is permitted when:

    The beneficiary is unable to sign his/her name because of illiteracy or physical handicap.

3. Another person may sign on behalf of the beneficiary when:

    a) A beneficiary who is a resident of a nonprofit retirement home gives power of attorney to the administrator of the home.

    b) A beneficiary is physically or mentally unable to transact business—the request may be signed by a representative payee, legal representative, relative, friend, representative of an institution providing the beneficiary care/support, or a representative of a governmental agency providing him/her assistance.

    c) A beneficiary is physically or mentally unable to transact business and full documentation is supplied that the beneficiary has no one else to sign on his/her behalf—the physician, supplier, or clinic may sign.

    d) The beneficiary is deceased and the bill is paid or liability assumed—the person claiming payment should sign. If Form CMS-1500 was signed before the enrollee dies, claimant should sign separate request for underpayment.

4. When the request retained in your file may cover an extended future period:

    a) Assignment in files of a welfare agency covers all services furnished during the period when the enrollee is on medical assistance.

    b) Authorization in files of organization approved under the indirect payment procedure (CMS Pub. 100-4, Chapter 1, § 30.2.8.3) covers all services paid for by that organization.

    c) Assignment in the files of group practice prepayment plan covers services furnished by the plan during the period of the beneficiary's membership.

    d) Assignment in the files of a participating provider (hospital, SNF, home health agency, outpatient physical or speech therapy provider or comprehensive rehabilitation facility) or ESRD facility covers physician services for which the provider or facility is authorized to bill, and may cover the physician services furnished in the provider or facility as follows:

        - Inpatient services - effective for period of confinement.

        - Outpatient services - effective indefinitely.

e) Assignment in files of individual physician, supplier (except in the case of unassigned claims for rental of durable medical equipment), or qualified reassignee under CMS Pub. 100-4, Chapter 1, § 30.2 - Assignment of Provider's Right to Payment, is effective indefinitely.

You may obtain and retain in your files a one-time payment authorization from a beneficiary (or the beneficiary's representative) applicable to any current and future services. You should have the beneficiary sign a brief statement such as:

Name of Beneficiary HICN/MBI

I request that payment of authorized Medicare benefits be made either to me or on my behalf to (supplier)_____ for any services furnished me by that supplier. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature_____ Date_____

Once you have obtained the beneficiary's one-time authorization, later claims can be filed without obtaining an additional signature from the beneficiary. These claims may be on an assigned or non-assigned basis with the exception of durable medical equipment rentals. The one-time authorization for DME rental claims is limited to assigned claims.

7. Claim Filing Jurisdiction

Unlike other Medicare claims, DMEPOS claim jurisdiction is based on the beneficiary's address on file with the Social Security Administration. A DMEPOS claim should be sent to the DME MAC jurisdiction for the state in which the beneficiary resides.

For a listing of the four DME MAC jurisdictions with the included states/territories and the addresses to which paper claims should be filed, refer to Chapter 15 of this manual.

8. Time Limit for Filing Claims

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 1, §70

All Medicare claims for services must be filed within one year after the date of service. For example, if the date of service took place on April 1, 2016, then the claim must be filed by April 1, 2017, in order to be considered for payment.

Effects of Time Limitations

If you accept assignment within the time limit for filing and then delay submission of the claim until no payment can be made to you or the beneficiary, you cannot charge the beneficiary for the services shown on the bill except for the 20 percent coinsurance and any unmet part of the deductible.

9. Clean Claims – Payment Floor and Ceiling

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 1, §80.2.1.2

A "clean" claim is one that does not require investigation or development outside the DME MAC operation on a prepayment basis.

A "paper claim" is one that is submitted on paper.

An "electronic claim" is one that is received by the DME MAC via tape, direct data entry, modem, etc.

The Medicare statute provides for claims payment "floors" and "ceilings." A floor is the minimum amount of time a claim must be held before payment can be released. A ceiling is the maximum time allowed for processing a "clean" claim before Medicare owes interest to a supplier of services.

If you file paper claims, you will not be paid before the 29th day after the date of receipt of your claims (i.e., a 28-day payment floor). However, clean claims filed electronically can be paid as early as 14 days after receipt (i.e., a 13-day payment floor).

The difference in payment floors is further incentive for you to consider use of electronic claims submission to improve your cash flow, record keeping, and claim status tracking ability.

The DME MAC has a 30-day ceiling to process a clean claim. On the 31st day after the date of receipt for clean claims (electronic and paper) that are not yet paid, interest will be owed.

10. Electronic Funds Transfer (EFT)

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 24, §60.5.3

Electronic Funds Transfer (EFT) is the process through which payment on Medicare claims is electronically transferred directly to your bank account. This process eliminates mail and deposit time and is available to all suppliers. As your Medicare contractor, we can deposit your Medicare payments directly into your bank account via Electronic Funds Transfer. EFT benefits us as well as other taxpayers because it reduces Medicare administrative spending by eliminating the process of issuing paper checks and the postage costs for mailing.

Other benefits to the Electronic Funds Transfer process are:

- Quicker payment
- Increased convenience
- Assurance of timely payment in the bank
- Elimination of multi-handling risks
- Prevention of lost or delayed checks
- Easier bank reconciliation
- Administration efficiency

There are no charges for EFT and you do not have to file your claims electronically to receive your payments sent by direct deposit.

You must complete and submit the most current version of the Authorization Agreement for Electronic Funds Transfer (CMS-588) to the appropriate NPE when initially enrolling a physical

location or submitting an application for a new location. Your bank information must be applicable for all four DME MAC Jurisdictions.

If you need to make changes to existing EFT information, submit updates to the appropriate NPE for processing.

Along with each completed CMS-588 form, you must include one of the following verifying the account information:

- Voided check
- Deposit slip
- Notification on bank letterhead verifying the account information

Please note that the DME MAC is not able to answer inquiries pertaining to EFT applications. Instead, you must contact the NPE.

11. Place of Service

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 26, §10.5

For DMEPOS claims, the place of service is considered to be the place where the beneficiary will primarily use the DMEPOS item. Coverage for any DMEPOS items will be considered if the place of service is:

01	Pharmacy
04	Homeless Shelter
12	Home
13	Assisted Living Facility
14	Group Home
16	Temporary Lodging
27	Outreach Site/Street
33	Custodial Care Facility
54	Intermediate Care Facility/Individuals with Intellectual Disabilities
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center

65	End Stage Renal Disease Treatment Facility (valid POS for Parenteral Nutritional Therapy)
66	Programs of All-Inclusive Care for the Elderly (PACE) Center

Coverage consideration for DMEPOS items in a Skilled Nursing Facility (31), unless the beneficiary is in a covered Part A stay**, or a Nursing Facility (32) is limited to the following:

- Prosthetics, orthotics and related supplies
- Urinary incontinence supplies
- Ostomy supplies
- Surgical dressings
- Oral anticancer drugs
- Oral antiemetic drugs
- Therapeutic shoes for Diabetics
- Parenteral/enteral nutrition (including E0776BA, the IV pole used to administer parenteral/enteral nutrition and supplies)
- Immunosuppressive drugs
- Lymphedema Compression Treatment Items

A complete list of place of service codes is available on the CMS website at https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html, as well as in the Internet-only Manual (IOM): CMS Manual System, Pub. 100-04, Medicare Claims Processing Manual, Chapter 26, §10.5. You can access the IOM at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html.

**It is important to note that this list does not apply to situations in which the beneficiary is in a Part A covered Skilled Nursing Facility (SNF) stay. Please see the "Consolidated Billing" section below for information regarding DMEPOS items when the beneficiary's SNF stay is covered by Part A.

12. Consolidated Billing

Skilled Nursing Facility (SNF) Residents

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 20, §211

Section 4432(b) of the Balanced Budget Act (BBA) requires Consolidated Billing (CB) for the SNF. The CB requirement essentially confers on the SNF itself the Medicare billing responsibility for the entire package of care that its residents receive, except for a limited number of specifically excluded services.

For services and supplies furnished to a SNF resident covered under the Part A benefit, SNFs are not able to unbundle services to an outside provider of services or supplies that can then submit a

separate bill directly to the Medicare Contractor. Instead, the SNF must furnish the services or supplies either directly or under an arrangement with an outside provider. The SNF, rather than the provider of the service or supplies, bills Medicare. Medicare does not pay amounts that are due a provider of the services or supplies to any other entity under assignment, power of attorney, or any other direct payment arrangement (See 42 CFR 424.73.). **As a result, if you have supplied an item or service to a beneficiary who is a resident in a covered Part A stay, you must look to the SNF, rather than to the beneficiary or the DME MAC, for payment.** The SNF may collect any applicable deductible or coinsurance from the beneficiary. Most covered services and supplies billed by the SNF, including those furnished under arrangement with an outside provider, for a resident of a SNF in a covered Part A stay are included in the SNF's bill to the A/B MAC.

It is your responsibility to check with the facility to see if your patient is a resident in a covered Part A stay. If so, all services must be billed to Medicare by the SNF except for certain excluded items. A complete list of these excluded items (listed by HCPCS code) may be found on the CMS website at https://www.cms.gov/medicare/coding-billing/skilled-nursing-facility-snf-consolidated-billing. **If a HCPCS code appears on this list, then it may be billed to the DME MAC for payment, even if the beneficiary is in a covered Part A SNF stay.** *Note: in order to access the list, click on the link above, select the appropriate "Part A MAC Update" (whichever year in which the service took place), and then open the ZIP file found in the Downloads section.*

SNF Consolidated Billing - Capped Rental DME

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 20, §211

Medicare pays for durable medical equipment (DME) when it is medically necessary for use in a beneficiary's home.

For capped rental items of DME in which you submit a monthly bill, the date of delivery on the first claim must be the "from" or anniversary date on all subsequent claims for the item.

The DME benefit is only meant for items a beneficiary is using in his or her home. For a beneficiary in a Part A stay, a SNF is not defined as a beneficiary's home. Medicare does not make separate payment for DME when a beneficiary is in a SNF. The SNF is expected to provide all medically necessary DMEPOS during a beneficiary's covered Part A stay.

However, in accordance with DMEPOS payment policy, Medicare will make a separate payment for a full month of rental for DME items, provided the beneficiary was in the home on the "from" date or anniversary date defined above. Medicare will make payment for the entire month, even if the "from" date is the date of discharge from the SNF.

If a beneficiary using DME is in a covered Part A stay in a SNF for a full month, Medicare will not make payment for the DME for that month.

If the beneficiary is in a Part A covered stay, but not for the entire month, the discharge date becomes the new anniversary date for subsequent claims. In this situation, you must submit a new claim using the date of discharge as the "from" date. You should note in the NTE segment/line note (field 19 for paper claims) that the beneficiary was in a SNF, resulting in the need to establish a new anniversary date.

Home Health Prospective Payment System (PPS)

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 20, §140.2

The Balanced Budget Act of 1997 requires consolidated billing of all home health services while a beneficiary is under a home health plan of care authorized by a physician (referred to as a "home health episode"). Consequently, billing for all such items and services will be made to a single home health agency (HHA) overseeing that plan.

The law states that payment will be made to the primary HHA whether or not the item or service was furnished by the agency, by others under arrangement to the primary agency, or when any other contracting or consulting arrangements existed with the primary agency, or "otherwise." Payment for all items is scheduled in the home health PPS episode payment that the primary HHA receives.

Types of services that are subject to the home health consolidated billing provision include:

- Skilled nursing care;
- Home health aide services;
- Physical therapy;
- Speech-language pathology;
- Occupational therapy;
- Medical social services;
- Routine and non-routine medical supplies (see below);
- Medical services provided by an intern or resident-in-training of a hospital, under an approved teaching program of the hospital, in the case of a HHA that is affiliated or under common control with that hospital; and
- Care for homebound patients involving equipment too cumbersome to take to the home.

Routine and Non-Routine Medical Supplies

When a beneficiary is in a 60-day home health episode, these items are included in the PPS episode payment. HHAs must bill for all supplies provided during the 60-day episode, including those not related to the Plan of Care, because of the consolidated billing requirements.

The "Home Health Consolidated Billing Master Code List" is a list of the HCPCS codes which apply to home health consolidated billing. It is available on the CMS website at https://www.cms.gov/medicare/payment/prospective-payment-systems/home-health/coding-and-billing-information. **If a HCPCS code appears on this list, it may not be billed to the DME MAC when the beneficiary is in a home health episode.**

13. DMEPOS and an Inpatient Stay

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 20, §110.3

Pre-Discharge Delivery of DMEPOS for Fitting and Training

The following are CMS policy and billing procedures regarding the circumstances under which you may deliver durable medical equipment, prosthetics, and orthotics (but not supplies) to a beneficiary who is in an inpatient facility that does not qualify as the beneficiary's home.

Conditions That Must Be Met:

In some cases, it would be appropriate for a supplier to deliver a medically necessary item of durable medical equipment (DME), a prosthetic, or an orthotic—but not supplies—to a beneficiary who is an inpatient in a facility that does not qualify as the beneficiary's home. The CMS will presume that the

pre-discharge delivery of DME, a prosthetic, or an orthotic (hereafter referred to as “item”) is appropriate when all the following conditions are met:

The item is medically necessary for use by the beneficiary in the beneficiary's home.

1. The item is medically necessary on the date of discharge, i.e., there is a physician's order with a stated initial date of need that is no later than the date of discharge for home use.

2. The supplier delivers the item to the beneficiary in the facility solely for the purpose of fitting the beneficiary for the item, or training the beneficiary in the use of the item, and the item is for subsequent use in the beneficiary's home.

3. The supplier delivers the item to the beneficiary no earlier than two days before the day the facility discharges the beneficiary.

4. The supplier ensures that the beneficiary takes the item home, or the supplier picks up the item at the facility and delivers it to the beneficiary's home on the date of discharge.

5. The reason the supplier furnishes the item is not for the purpose of eliminating the facility's responsibility to provide an item that is medically necessary for the beneficiary's use or treatment while the beneficiary is in the facility. Such items are included in the Diagnostic Related Group (DRG) or Prospective Payment System (PPS) rates.

6. The supplier does not claim payment for the item for any day prior to the date of discharge.

7. The supplier does not claim payment for additional costs that the supplier incurs in ensuring that the item is delivered to the beneficiary's home on the date of discharge. The supplier cannot bill the beneficiary for redelivery.

8. The beneficiary's discharge must be to a qualified place of service, e.g., home, custodial care facility, but not to another facility (e.g., inpatient or skilled nursing) that does not qualify as the beneficiary's home.

Date of Service for Pre-Discharge Delivery of DMEPOS:

For DMEPOS, the general rule is that the date of service is equal to the date of delivery. However, pre-discharge delivery of items intended for use upon discharge is considered provided on the date of discharge. In this case, the date of service on the claim should be the date of discharge.

14. DMEPOS and Hospice

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 20, §10.2

When hospice coverage is elected, the beneficiary waives all rights to Medicare Part B payments for services that are related to the treatment and management of his/her terminal illness. During any period in which the hospice benefit election is in force, all items related to the treatment and management of his/her terminal illness are paid by the intermediary. If the items are not related to the terminal illness, the supplier should submit the claim to the DME MAC.

For services provided to a beneficiary enrolled in a plan participating in the Value Based Insurance Design (VBID) Model’s hospice benefit component, Medicare will deny payment for all claims with dates of service during a hospice election (with a hospice election start date on or after January 1, 2021, through December 31, 2024) and upon discharge or revocation, through the end of the month.

Suppliers MUST still submit claims for these services to Medicare and can expect the following messaging:

- Claim Adjustment Reason Code (CARC) 96: Non-covered charge(s)
- Remittance Advice Remark Code (RARC) MA73: Information remittance associated with a Medicare demonstration. No payment issued under Fee-For-Service Medicare as patient has elected managed care
- Group Code CO

15. Upgrades

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 30, §50.13

A. ABNs for Upgrades

An upgrade is an item with features that go beyond what is medically necessary. DME upgrades involve situations in which the upgraded item or component has a different HCPCS code than the item that will be covered by Medicare. Advance Beneficiary Notices of Non-Coverage (ABNs) cannot be used to charge beneficiaries for premium quality services described as “excess components.” Similarly, ABNs cannot be used to shift liability for an item or service that is described on the ABN as being “better” or “higher quality” on an ABN but do not exceed the HCPCS code description.

When you know or believe that the DMEPOS item does or may not meet Medicare’s reasonable and necessary rules under specific circumstances, it is your responsibility to notify the beneficiary in writing via an ABN if you want to collect money from a beneficiary if an item is denied.

When you furnish an upgraded item of DMEPOS and you expect Medicare to reduce the level of payment based on a medical necessity partial denial of coverage for additional expenses attributable to the upgrade, you must give an ABN to the beneficiary for signature in order to hold the beneficiary liable for the additional expense.

See Chapter 3 of this manual for information about ABNs.

General Instructions for the Use of ABNs for Upgrading DMEPOS Items

1. DME upgrades involve situations in which the upgraded item or component has a different HCPCS code than the item that will be covered by Medicare. ABNs cannot be used to charge beneficiaries for premium quality services described as “excess components.”

2. The upgrade must be within the range of items or services that are medically appropriate for the beneficiary’s medical condition and the purpose of the physician’s order. ABNs may not be used to substitute a different item or service that is not medically appropriate for the beneficiary’s medical condition for the original item or service. The upgraded item must still meet the intended medical purpose of the item the physician ordered.

3. Use of an ABN to furnish an upgraded item or service, with the beneficiary being personally responsible for the difference between the costs of the standard and upgraded item or service, does not change coverage or payment rules, statutory provisions, or manual instructions for the particular benefit involved.

4. In cases where the DME MACs would make payment for the item the physician ordered on a rental basis, you must furnish the upgrade on a rental basis.

5. If you are furnishing an upgrade and using an ABN, you must submit a claim and include information on the claim that identifies the upgrade features. You must submit a claim for upgraded items and services using the GA modifier on the upgraded line item to indicate that the beneficiary signed an ABN. For paper claims, you must list upgrade features in Item 19 of the CMS-1500 form or as an attachment to the claim. For electronic claims, you must use the NTE segment/line note on the 837 electronic claim format.

6. Denials should be based on medical necessity.

Billing Instructions

You must bill two line items for upgraded DMEPOS items where the beneficiary requests an upgrade. You must bill both lines on the same claim in the following order:

Line 1: Bill the appropriate HCPCS code for the upgraded item that you actually provided to the beneficiary with the dollar amount of the upgraded item. If you have a properly obtained ABN on file signed by the beneficiary, use the GA modifier. If you did not properly obtain an ABN signed by the beneficiary, use the GZ modifier.

Line 2: Bill the appropriate HCPCS code for the reasonable and necessary item with the actual charge for the item. Use the GK modifier.

You must bill your full submitted charge on the claim line for the upgraded item (Line 1) and the full amount for the reasonable and necessary item (Line 2). If the upgrade is within a code, you still bill two line items, using the same code on both lines, but Line 1 would have the higher dollar amount. You must bill both lines on the same claim in sequential order. Line 1 and the associated Line 2 must follow each other.

Claims that have invalid ABN upgrade information will be returned as unprocessable.

Definitions of Modifiers that May be Associated with ABNs

GA – Waiver of Liability Statement on file (expected to be denied as not reasonable and necessary, ABN on file)

GZ – Item or Service not Reasonable or Necessary (expected to be denied as not reasonable and necessary, no ABN on file)

GK – Reasonable and necessary item/service associated with GA or GZ modifier

B. Providing Upgrades of DMEPOS without Any Extra Charge

Instead of using ABNs and charging beneficiaries for upgraded items, suppliers in certain circumstances may decide to furnish beneficiaries with upgraded equipment but charge the Medicare program and the beneficiary the same price they would charge for a non-upgraded item. The reason for this may be that a supplier prefers to carry only higher level models of medical equipment in order to reduce the costs of maintaining an inventory that includes a wide variety of different models and products. Also, a supplier may be able to reduce its costs for replacement parts and repairs if it includes in its inventory only certain product lines. The supplier may also be accommodating a physician order for an upgrade.

Policy

You are permitted to furnish upgraded DMEPOS items and to charge the same price to Medicare and the beneficiary that they would charge for a non-upgraded item. This policy allows you to furnish

to beneficiaries, at no extra costs to the Medicare program or the beneficiary, a DMEPOS item that exceeds the non-upgraded item that Medicare considers to be medically necessary. Therefore, even though the beneficiary received an upgraded DMEPOS item, Medicare's payment and the beneficiary's coinsurance would be based on the Medicare allowed amount for a non-upgraded item that does not include features that exceed the beneficiary's medical needs.

Billing Instructions

When you decide to furnish an upgraded DMEPOS item but not charge Medicare and the beneficiary for the non-upgraded item, you must bill for the non-upgraded item rather than the item you actually furnished. The claim must include only the charge and HCPCS code for the non-upgraded item. The HCPCS code for the non-upgraded item must be accompanied by the following modifier:

GL – Medically Unnecessary Upgrade Provided Instead of Non-upgraded Item, No Charge, No ABN

In Item 19 of a paper claim, or as an attachment, you must specify the make and model of the item actually furnished (the upgraded item) and describe why this item is an upgrade. For electronic claims, you must use the NTE segment/line note on the 837 electronic claim format.

The DME MAC pays based on Medicare's payment amount for the non-upgraded item if it meets Medicare's coverage and payment requirements. A Certificate of Medical Necessity (CMN), if applicable, must be completed for the HCPCS code that identifies the non-upgraded item, but not for the upgraded item.

C. DMEPOS Upgrade Chart

The following chart indicates upgrade situations in which an ABN is required, the claim modifiers needed, and whether or not the beneficiary is responsible for payment of the upgrade.

Upgrade Situation	ABN Required	Required Modifier(s)	DME MAC Payment	Beneficiary Pays for Upgrade
1. Physician orders upgrade:				
a. Supplier provides upgrade free of charge to beneficiary	No	GL	R&N item only (GL line)	No
b. Supplier bills beneficiary for upgrade	Yes	GA/GK	R&N item only (GK line)	Yes
2. Patient requests upgrade:				
a. Supplier provides upgrade free of charge to beneficiary	No	GZ/GK	R&N item only (GK line)	No
b. Supplier bills beneficiary for upgrade	Yes	GA/GK	R&N item only (GK line)	Yes

3. Supplier provides upgrade for supplier convenience:

a. Supplier provides upgrade free of charge to beneficiary	No	GL	R&N item only (GL line)	No

Table Footnotes:

GK or GL is added to the HCPCS code for the item that meets Medicare coverage requirements. When GK is used, GA or GZ is added to the HCPCS code for the item that is provided. See the sections above for further details.

R&N = Reasonable and necessary

16. PWK (Paperwork) Segment

When submitting an electronic claim, there may be times when additional documentation is needed in order for the claim to be properly adjudicated. If the information can be sent using the claim narrative (NTE segment), we encourage you to use the NTE segment. In instances when the NTE or narrative segment is insufficient, the PWK (paperwork) segment is a function within the 837 Professional and Institutional electronic transactions which allows for an electronic submission of additional claim documentation via mail or fax. Use of the PWK segment is entirely voluntary. Refer to Chapter 8 of this manual for additional information about electronic claim submission.

If using the PWK segment, please keep the following in mind:

- You must use the PWK Fax/Mail Cover Sheet (http://www.cgsmedicare.com/jb/forms/pdf/pwk_coversheet.pdf), available on our website at https://www.cgsmedicare.com/jb/forms/index.html.
- You must send the additional documentation AFTER the claim has been electronically submitted and accepted with the PWK segment.
- You must accurately and completely record data on the fax/mail cover sheet that relates the faxed/mailed data to the PWK Loop on the claim.
- If PWK data submission is incomplete or incorrectly filled out, the DME MAC will manually return the cover sheet and all attachments.
- Use of the PWK segment does not guarantee that the DME MAC will review the submitted paperwork. Additional claim documentation (including the claim narrative) is only reviewed when needed by the DME MAC.
- When needed for claim adjudication, the DME MAC will allow seven calendar “waiting” days (from the date of receipt) for additional information to be faxed or ten calendar “waiting” days for additional information to be mailed.
- You must send ALL relevant PWK data at the same time for the same claim.

- If the additional documentation is not received within the seven calendar waiting days for faxes or ten calendar waiting days for mailed submissions, the DME MAC will begin normal processing procedures on your claim.
- If the PWK documentation is not sufficient in a given situation, the DME MAC may send a development request for specific claim documentation.
- Medicare will not send the PWK documentation to the Coordination of Benefits Contractor to accompany crossover claims.

17. Electronic Submission of Medical Documentation (esMD)

Electronic Submission of Medical Documentation (esMD) is a way to submit electronic documentation **after** it has been requested by the DME MAC. If you receive a request for additional documentation from Jurisdiction B and wish to respond electronically, you can submit your documentation (as a PDF file) through the CMS esMD gateway. We will receive your file and process your claim accordingly.

For information about how to connect to the esMD gateway, as well as additional information about esMD, visit the CMS esMD Web page at https://www.cms.gov/data-research/computer-data-systems/esmd.

Please note that you may only submit esMD documentation for a claim if you have received a documentation request letter from DME MAC Jurisdiction B that contains a documentation case ID number or if you are submitting a Prior Authorization Request for a code that is part of the Prior Authorization Demonstration.