



Medicare Hospital Version

KEY CONCEPTS OUTLINE

Module 4: Medicare Claims Submission Fundamentals

I. The UB-04 Form/837 I Electronic Format

A. The UB-04/837I format is used by Medicare for “provider” claims.

1. Handout 5 is a hardcopy UB-04 claim form.

B. CMS has instructed providers to obtain code descriptions from the National Uniform Billing Committee (NUBC) or from the local MAC. <Medicare Claims Processing Manual Transmittal 1973>

1. The *Official UB-04 Data Specifications Manual* (NUBC Manual) contains the official code descriptions for fields on the UB-04, as well as the meeting minutes of the NUBC committee, which may be helpful to understand new codes and changes to existing code descriptions.
 - a. The NUBC manual can be obtained by subscribing through the American Hospital Association’s bookstore. Information can be found on the NUBC website at: www.nubc.org.
 - b. The NUBC Manual is released on July 1 of every year, i.e., the 2024 version was released July 1, 2023.
2. CMS continues to communicate specific code implementation direction via change requests (CRs), i.e., transmittals. <Medicare Claims Processing Manual Transmittal 1973>

II. Key UB-04 Fields Applicable to Hospital Services

A. Billing Provider Name, Address and Telephone Number (FL 01)

1. Identifies the street address or physical location where the service was rendered, including the 9-digit zip code. <Workgroup for Electronic Data Interchange (WEDI) Frequently Asked Questions, 5010 837 Billing Provider Address, April 28, 2011; *Medicare Claims Processing Manual*, Chapter 1 § 170.1.1; NUBC August 7-8, 2007, Meeting Minutes, Issue 8, page 962>

- a. The 9-digit zip code reported in this field is used to determine the applicable payment locality where used (e.g., the Medicare Physician Fee Schedule).
<Medicare Claims Processing Manual, Chapter 1 § 170.1.1>

2. Services Rendered at More Than One Location:

- a. If any service is provided at the main facility address, even if services are also provided at a PBD:
 - i. Report only the main provider address in UB04 FL01 on a paper claim (FL01) or the 837I billing provider loop 2010AA on an electronic claim (2010AA); and
 - ii. Do not report the PBD address in the 837I service facility address loop 2310E on an electronic claim (2310E) or in the DDE MAP 171F screen (171F). <See *MLN Matters SE18002, SE18023, see SE19007*>
- b. If any service is provided at a remote location, but not the main facility address, even if services are also provided at a PBD:
 - i. Report the main provider address in 2010AA;
 - ii. Report the remote campus address in FL01, 2310E, or 171F; and
 - iii. Do not report the PBD address in FL01, 2310E, or 171F. <See *MLN Matters SE18002, SE18023, see SE19007*>
- c. If all services are provided at a single PBD location:
 - i. Report the main provider address in 2010AA; and
 - ii. Report the PBD address in FL01, 2310E, or 171F. <See *MLN Matters SE18002, SE18023, see SE19007*>
- d. If services are provided at more than one PBD location, but not at the main facility address or remote location:
 - i. Report the main provider address in 2010AA;
 - ii. Report the address of the PBD that provided the first registered encounter reported on the claim in FL01, 2310E or 171F. <See *MLN Matters SE18002, SE18023, see SE19007*>

- e. An address reported in 2310E or 171F must match (including alphanumeric characters, spaces, and punctuation) an address in the hospital's enrollment information in PECOS or the claim will be returned to the provider (RTP'd) for correction. <See *MLN Matters SE19007*>
- i. In DDE, the address on record with PECOS can be verified on the MAP1AB1 and MAP1AB2 screens. See instructions in *MLN Matters SE19007*.
- ii. Services reported with Condition Code A7 (hospital service provided in a mobile facility or portable unit) bypass the service address matching edits. <*Medicare One Time Notification Transmittal 2394*>

B. Bill Type (FL 04)

1. The most common bill types used by hospitals include:
 - a. Inpatient Part A – 011X;
 - b. Inpatient Part B – 012X;
 - c. Outpatient Part B – 013X;
 - d. Non-patient diagnostic laboratory – 014X; and
 - e. Outpatient Critical Access Hospital – 085X.
2. The last digit of the bill type, often represented by the variable X in CMS policies, is filled in with a frequency code, e.g., 1 for “admit through discharge” or 7 for an “adjustment claim”.

C. Statement Covers Period (From-Through) (FL 06)

1. Indicates the dates of service included on the claim, with the “from” date being the earliest date of service on the claim. <*MLN Matters Article SE1117*>

D. Admission/Start of Care Date (FL 12)

1. Required on inpatient claims to indicate the admission date of the patient.
 - a. The date of inpatient admission is the date of the doctor's order for inpatient care. <42 C.F.R. 412.3, *Medicare Claims Processing Manual*, Chapter 3 § 40.2.2 K>

- i. If the patient dies or is discharged prior to being assigned and/or occupying a room, the patient is nonetheless considered an inpatient on the date of the admission order and the hospital may charge for room and board. <Medicare Claims Processing Manual, Chapter 3 § 40.2.2 K>

Example: A patient is seen in the ED on Monday evening. The physician writes an inpatient admission order at 10:00 p.m. on Monday. The patient remains in the ED until 2:30 a.m. on Tuesday, at which time the patient is transported to an inpatient bed. The date of admission is Monday.

2. The admission date need not match the statement “from” date in FL 6 and may be after the “from” date, if appropriate. <MLN Matters Article SE1117>

E. Patient Discharge Status (FL 17)

1. Indicates the patient status (i.e., discharged, transferred, etc.) as of the “through” date of the billing period.

Tip: CMS published Special Edition MLN Matters Article SE1411 to clarify the use of Patient Discharge Status codes.

F. Condition Codes (FLs 18-28)

1. Used to communicate various types of claim/beneficiary specific information to the MAC (e.g., Condition Code 44 is used to indicate an inpatient admission that was changed to outpatient following a UR determination).

G. Occurrence Codes (FLs 31-34)

1. Used to communicate the occurrence of an event (and the date of the event) to the MAC (e.g., Occurrence Code 32 is used to indicate the date a patient was given an ABN).

H. Occurrence Span Codes (FLs 35-36)

1. Used to communicate the beginning and ending dates for a particular event (e.g., Occurrence Span Code 72 denotes a contiguous outpatient service that precedes an inpatient admission).

I. Value Codes (FLs 39-41)

1. Used to communicate a dollar amount, unit amount or other similar information required for some types of claims (e.g., Value Code 48 is used to indicate the most recent hemoglobin reading to verify coverage of Epoetin).

J. Revenue Codes (FL 42)

1. Indicates the revenue center for each charge included on the bill.
 - a. Used to capture charges by revenue center for cost/charge-based payment purposes and for cost report reconciliation.
2. If CMS has not provided explicit instructions, hospitals should “report their charges under the revenue code that will result in the charges being assigned to the same cost center to which the cost of those services are assigned in the cost report.” <Medicare Claims Processing Manual, Chapter 4 § 20.5>
 - a. A crosswalk of revenue code to cost center mapping is posted on the CMS website.

Link: Revenue Code to Cost Center Crosswalk under Medicare-Related Sites – Hospital

3. Hospitals should choose the most precise revenue code or subcode when applicable rather than the “0” (General) or “9” (Other) categories. <Medicare Claims Processing Manual Transmittal 1599, 1. Revenue Code Reporting>
4. Revenue codes are validated (i.e., checked for effective date, deactivation, etc.) based on the claims processing receipt date rather than the claim from and through date or line-item date of service. <IOCE Specifications, Section 5.3.3>

K. HCPCS Codes/Rates (FL 44)

1. On inpatient claims, used to report the accommodation rate.
 - a. Blood Clotting Factor Add-on Payment:
 - i. Hospitals do not generally use HCPCS codes for reporting inpatient services, however, to receive the hemophilia blood clotting factor add-on payment the hospital must report Revenue Code 0636 and a HCPCS code with the number of units administered reported in the unit field. <Medicare Claims Processing Manual, Chapter 3 § 20.7.3>
 - ii. The blood clotting factor add-on payment is only available if the patient has a specified hemophilia diagnosis code, listed in the *Medicare Claims Processing Manual*, Chapter 3 § 20.7.3.
2. On outpatient claims, used to report HCPCS codes (i.e., CPT (HCPCS Level I) and HCPCS Level II codes. Handout 6 is a diagram of coding systems for reference.

- a. Reporting HCPCS codes is generally required for hospitals paid under the OPPS, where they exist, and should be consistent with the HCPCS long descriptor. <Medicare Claims Processing Manual, Chapter 4 § 20.1>
 - i. The edit requiring a HCPCS code is bypassed (i.e., no HCPCS code is required) if:
 - a) The revenue code has status indicator F (Cost-based CRNA services);
 - b) The revenue code has status indicator N (Packaged services); or
 - c) The revenue code is designated as “Bypass_E48. <IOCE Specifications, Section 8.2, Edit 48>
 - ii. The status indicator and other edit information for revenue codes is available in the IOCE Quarterly Data file, Report-Table, Data_Revenue. The list of status indicator F, N, and bypass 48 codes is included in the materials behind the outline. The IOCE will be discussed in more detail in a later module.

Note: CMS’ edits allowing revenue codes to be reported without HCPCS codes do not match the NUBC Manual designations for reporting of HCPCS codes.

- b. Unless specifically indicated, hospitals may report any HCPCS code without regard to the term “physician” in the descriptor. <Medicare Claims Processing Manual, Chapter 4 § 20.2>

Tip: The term “physician” used in HCPCS code descriptors or coding policies applies to hospitals and other practitioners eligible to bill the HCPCS code under applicable Medicare coverage and payment provisions.

- c. If a separate code exists for reporting the technical component of a service, the hospital should report the technical component code for their services. <Medicare Claims Processing Manual, Chapter 4 § 20.2>
 - d. If no separate code exists for the technical component of a service, the hospital should report the code that represents that complete procedure. <Medicare Claims Processing Manual, Chapter 4 § 20.2>
3. Modifiers are two-digit codes, consisting of letters and numbers, that are reported after HCPCS codes to provide more information about the code. <Medicare Claims Processing Manual, Chapter 4 § 20.6>

- a. Modifiers may bypass code edits, trigger payment modifications or simply be informational.
- b. Modifiers should only be appended to HCPCS codes if the clinical circumstances justify the use of the modifier and must be used if the payment or informational conditions for use of the modifier have been met. <NCCI Policy Manual, Chapter 1 (E)>
- c. MACs are required to accept and process up to four modifiers and may not drop them before complete processing. <Medicare Claims Processing Manual, Chapter 4 § 20.6.1 and Chapter 23 § 20.3>

L. Principal Diagnosis Code (FL 67)

- 1. For inpatient claims, used to report the “principal” diagnosis.
 - a. The principal diagnosis is “the condition established after study to be chiefly responsible for [the] admission.” <Official ICD-10-CM Guidelines for Coding and Reporting, Section II>
- 2. For outpatient claims, used to report the “first-listed” diagnosis.
 - a. The “principal diagnosis” concept does not apply to outpatient services. <Official ICD-10-CM Guidelines for Coding and Reporting, Section IV(A)>
 - b. The first-listed diagnosis is the “diagnosis, condition, problem, or other reason for [the] encounter/visit shown in the medical record to be chiefly responsible for the services provided.” <Official ICD-10-CM Guidelines for Coding and Reporting, IV (G)>
 - c. If a code identified as an unacceptable principal diagnosis code is reported on an outpatient claim, edit 113 of the IOCE will return the claim to the provider (RTP) unless the code is on the list of outpatient exclusions. <See IOCE Specifications, Section 8.2, Edit 113 (Supplement)>
 - i. The list of unacceptable principal diagnosis codes and outpatient exclusions are available in the IOCE Quarterly Data File, Report-Table folder, “Data_DX10” available on the IOCE homepage.

M. Other Diagnosis Codes (FLs 67A-Q)

- 1. Used to report additional diagnosis codes applicable to an encounter/admission.

2. Medicare claims systems accepts 24 additional diagnosis codes in addition to the principal diagnosis. <Medicare Claims Processing Manual, Chapter 3 § 20.2.1 C>

N. Present on Admission (POA) Indicator (FLs 67, 67A-Q, and 72 supplemental locator)

1. The POA is used to indicate whether a condition was present upon inpatient admission. <Official ICD-10-CM Guidelines for Coding and Reporting, Appendix I Present on Admission Reporting Guidelines, “General Reporting Requirements”>
2. Reporting of the POA indicator is required for inpatient claims submitted by hospitals paid under the Inpatient Prospective Payment System (IPPS) and Maryland Hospitals exempt from IPPS. <Medicare Claims Processing Manual Transmittal 1240; 78 Fed. Reg. 50524-25>
 - a. Critical Access Hospitals, Long Term Care Hospitals, Inpatient Rehabilitation Facilities, Inpatient Psychiatric Facilities, cancer hospitals, and children’s hospitals are exempt from POA reporting requirements. <One Time Notification Transmittal 354>

O. Admitting Diagnosis (FL 69)

1. For inpatient claims, the “condition identified by the physician at the time of the patient’s admission requiring hospitalization” must be reported in this field for all claims subject to review by the Quality Improvement Organization (QIO). <Medicare Claims Processing Manual, Chapter 25 § 75.6>
 - a. Although inpatient Part B claims (TOB 012X) are billing for part B payment, NUBC instructions require an admitting diagnosis in FL69 for TOB 012X claims. <NUBC Manual, FL69>

P. Patient’s Reason for Visit (FLs 70a-c)

1. For outpatient claims, the patient’s reason for the visit must be reported for claims with type of bill 013X (hospital outpatient) and 085X (critical access hospital outpatient) if:
 - a. The Priority (Type) of Admission or Visit is 1 (emergency), 2 (urgent), or 5 (trauma); and
 - b. Revenue codes 045X (emergency department), 0516 (urgent care clinic), or 0762 (observation hours) are reported. <Medicare Claims Processing Manual, Chapter 25 § 75.6>

2. Although signs and symptoms that are integral or related to the definitive diagnosis are not reported as additional diagnosis codes, they may be reported in FLs 70a-c. <MLN Matters Article 3437; Coding Clinic for ICD-9-CM, Third Quarter 2003>

Tip: The patient reason for visit may be reported on any claim type at the discretion of the provider if the information substantiates the medical necessity of the services rendered.

Case Study 1

Facts: A patient presents to the emergency department with chest pain (R07.9). Following testing, including an EKG and cardiac enzymes, the patient is diagnosed with a recurrence of Gastroesophageal Reflux Disease (GERD) (K21.0). What diagnosis or diagnoses codes should be reported on the claim and in what field or fields?

Q. Principal Procedure (FL 74) and Other Procedures (FLs 74A-E)

1. Required only for inpatient claims – used to report ICD-10-PCS procedure codes.
 - a. The principal procedure is “the procedure performed for definitive treatment rather than for diagnostic or exploratory purposes, or which was necessary to take care of a complication”.
2. Medicare inpatient claims systems process 24 procedures in addition to the principal procedure, for a total of 25. <Medicare Claims Processing Manual, Chapter 3 § 20.2.1>

III. Time Limitations on Filing Claims

- A. Medicare fee for service claims must be filed within one calendar year of the date of service. <One Time Notification Transmittal 697>
 1. For institutional claims, the “through” date on the claim will be used to determine the date of service for claims filing timeliness. <One Time Notification Transmittal 734; Medicare Claims Processing Manual, Chapter 1 § 70.1>
 2. There are four situations in which the provider can receive an exception to the time limit for filing claims. <Medicare Claims Processing Manual, Chapter 1 § 70.7>

- a. Error or misrepresentation by an employee, contractor or agent of CMS performing Medicare functions and acting within their scope of authority (administrative error). <Medicare Claims Processing Manual, Chapter 1 § 70.7.1>
 - b. Retroactive entitlement to Medicare after the time of service. <Medicare Claims Processing Manual, Chapter 1 § 70.7.2>
 - i. If the provider, supplier, or beneficiary is unable to provide the contractor with an official SSA letter detailing the retroactive entitlement, the MAC must check the Common Working File (CWF) to verify the date of entitlement and the date the beneficiary was notified of entitlement. <Medicare Claims Processing Manual, Chapter 1 § 70.7.2>
 - c. Retroactive entitlement to Medicare after the time of service where a state Medicaid agency recouped Medicaid payment for the service more than six months after the date of service. <Medicare Claims Processing Manual, Chapter 1 § 70.7.3>
 - d. Retroactive disenrollment from a Medicare Advantage Plan or Program of All-Inclusive Care for the Elderly (PACE) provider organization after the time of service where the plan or organization recouped their payment more than six months after the date of service. <Medicare Claims Processing Manual, Chapter 1 § 70.7.4>
3. The timely filing extension is until the last day of the sixth calendar month following the month in which the provider or supplier received notification the error is corrected; the beneficiary, provider or supplier received notification of retroactive entitlement; the state Medicaid agency recouped its funds; or the MA Plan or PACE provider recouped its money. <Medicare Claims Processing Manual, Chapter 1 § 70.7.1, 70.7.2, 70.2.3, 70.2.4>

IV. Adjustments and Reopening Requests

- A. A provider submits an adjustment claim to correct or supplement a claim that is within timely filing. <See MLN Matters Article SE1426>
 - 1. An adjustment claim has a bill type frequency code (i.e., the last digit of the type of bill) of “7”. <Official UB-04 Data Specifications Manual>
- B. A provider submits an automated reopening request to correct or supplement a claim that is beyond timely filing using bill type frequency code of “Q”. <See MLN Matters Article SE1426; Medicare Claims Processing Manual Transmittal 3219>

Requirements for a claim requesting an automated reopening:

- Bill type frequency code “Q”
- Condition code R1-R9 indicating the reason for reopening
- Condition code D0-D9 or E0 indicating the corrected/changed information
- Condition code W2 indicating there is no pending appeal
- For reopenings that require good cause, a statement of good cause
- A remark/note explaining the correction or change

For more information, see examples and code definitions in MLN Matters Article SE1426, included in the materials behind the outline.

1. Timeframes for provider requested reopenings:
 - a. Within one year of the date of the initial determination for any reason <Medicare Claims Processing Manual, Chapter 34 § 10.6.2>; or
 - b. Within four years of the date of the initial determination upon a showing of good cause <Medicare Claims Processing Manual, Chapter 34 § 10.6.2>; or
 - i. Good cause requires new and material evidence not available or known at the time of the initial determination or that the evidence used in making the initial determination shows on its face an obvious error. <Medicare Claims Processing Manual, Chapter 34 § 10.11>
 - ii. New and materials evidence may include medical records that were not required to be submitted at the time of the initial determination. <Medicare Claims Processing Manual, Chapter 34 § 10.11>
 - c. At any time to correct a clerical error. <Medicare Claims Processing Manual, Chapter 34 § 10.6.2>
 - i. A clerical error is defined as a mathematical or computational mistake, transposed procedure or diagnostic codes, inaccurate data entry, misapplication of a fee schedule, computer errors, claims incorrectly identified as duplicates, or incorrect data such a provider number, modifier, or date of service. <Medicare Claims Processing Manual, Chapter 34 § 10.4>
2. MACs may continue to allow other forms of reopening requests, such as hardcopy requests, in addition to this automated method of requesting a reopening. <See MLN Matters Article SE1426>

3. The decision to reopen a claim is within the MACs discretion and the provider may not appeal the MAC's decision to reopen or not reopen a claim. <See *MLN Matters Article SE1426; Medicare Claims Processing Manual*, Chapter 34 §§ 10 and 10.2; >
 - a. If a MAC decides not to grant the reopening request, they will RTP the claim requesting the reopening. <See *MLN Matters Article SE1426*>
4. A reopening will not be granted if an appeal is in process. <See *MLN Matters Article SE1426*>

Case Study 2

Facts: A hospital provided a diagnostic test on September 15, 2023, submitted a claim for the test on November 15, 2023, and received a denial for the test on December 1, 2023. How long does the hospital have to submit an adjustment request? A reopening?

V. Medicare Secondary Payer (MSP) Overview

- A. Medicare coverage is “secondary” to certain group health plan (GHP) coverage or non-group health plan (NGHP) coverage for accidental injuries (e.g., worker's compensation coverage, liability, or no-fault insurance). <*Medicare Secondary Payer Manual*, Chapter 1 § 20>
 1. Medicare payment cannot be made if payment has been or can reasonably be expected to be made under other coverage that is primary to Medicare. <42 C.F.R. § 411.20, *Medicare Secondary Payer Manual*, Chapter 1 § 20>
 2. If payment from the primary insurer(s) has not been or cannot be expected to be made promptly, Medicare may make a conditional payment, subject to repayment when the primary insurer(s) makes payment. <*Medicare Secondary Payer Manual*, Chapter 1 § 20>
 3. For a review of MSP rules and provisions, see the MLN Booklet *Medicare Secondary Payer* (MLN006903), available on the CMS website.

Link: Medicare Secondary Payer MLN Booklet under Medicare Related Sites - General

VI. Provider Responsibilities under MSP Provisions

- A. When Medicare is secondary to other insurance, the provider must seek payment from the primary insurer(s) before billing Medicare. <Medicare Secondary Payer Manual, Chapter 1 § 20>
- B. Prior to billing Medicare, a provider must determine if other insurance coverage is available and primary to Medicare for every visit, outpatient encounter, or inpatient admission by asking the beneficiary about other available insurance coverage. <Medicare Secondary Payer Manual, Chapter 3 § 20.1>

1. Types of Other Coverage the Provider Must Ask About

- a. Accidents or Incidents
 - i. Providers are required to ask if treatment is for an illness or injury resulting from an automobile or other accident or incident for which liability insurance, no-fault insurance or another party may be responsible, including accidents or incidents that occur on the provider's premises. <Medicare Secondary Payer Manual, Chapter 3 § 20.1 5.A.>
- b. Worker's Compensation
 - i. Providers are required to ask if the condition is work related at the time of admission or when services are rendered. <Medicare Secondary Payer Manual, Chapter 3 § 20.1 5.B.>
- c. GHP information for "Working Aged" Beneficiaries, Disabled Beneficiaries and ESRD beneficiaries. See below for information on the MSP questionnaire and HETS 270/271 transaction. <Medicare Secondary Payer Manual, Chapter 3 § 20.1 5.C., D., E.>

2. Verification of Other Insurance Coverage and MSP Questions

- a. CMS provides a set of model questions (MSP Questionnaire) to ask upon each inpatient admission and outpatient encounter to gather data from the beneficiary to determine the correct primary payer for services. <Medicare Secondary Payer Manual, Chapter 3 § 20.1, 20.2.1>

Regardless of whether the exact questions are used, the provider is responsible to determine the correct primary payer through eligibility inquiries and/or questions to the beneficiary.

- b. If the provider verifies the patient's insurance information with a Health Care Eligibility Benefit Inquiry (HETS 270/271 Transaction Set) or the CWF, the

provider need only ask if any insurance information has changed rather than completing the full MSP Questionnaire. <Medicare Secondary Payer Manual, Chapter 3 § 20.2>

- i. If there are changes or uncertainty as to the information provided by the beneficiary, the provider should complete the MSP Questionnaire. <Medicare Secondary Payer Manual, Chapter 3 § 20.2; MedLearns Matters Article MM10863>
- ii. Provider staff should make a notation that all MSP questions were not asked (i.e., the MSP Questionnaire was not filled out) based on the beneficiary's statement that their insurance information has not changed. <Medicare Secondary Payer Manual, Chapter 3 § 20.2>
- c. Even if the MSP Questionnaire is used, the provider still must review the MSP data in the HETS 270/271 or CWF MSP file either at admission or during the billing process. <Medicare Secondary Payer Manual, Chapter 3 § 20.2>
- d. The provider should keep a dated copy of the questions asked, the CWF print out or copy of the transaction 271 response for 10 years from the date of service to demonstrate that development of primary payer coverage took place. The copy may be kept online or hard copy. <Medicare Secondary Payer Manual, Chapter 3 § 20.2.2>

3. Exceptions

a. Reference Laboratory Services

- i. If no face-to-face encounter occurs for a laboratory service (e.g., processing of a reference laboratory sample), the provider is not required to develop MSP information, however, they should use MSP information they have on file to submit claims to the correct primary payer. <Medicare Secondary Payer Manual, Chapter 3 § 20.1 1.>
- ii. Although the provider is not required to collect information when there is no face-to-face encounter, Medicare continues to have the right of recovery on claims paid incorrectly due to the existence of a primary payer. <Medicare Secondary Payer Manual, Chapter 3 § 20.1 1.>

b. Recurring Outpatient Services

- i. For purposes of the MSP provisions, CMS defines recurring services as identical outpatient services or treatments occurring more than once in a billing cycle. <Medicare Secondary Payer Manual, Chapter 3 § 20.1 2.>

- ii. For recurring services, the provider must collect MSP information with the initial service and verify that information every 90 days. <Medicare Secondary Payer Manual, Chapter 3 § 20.1 2.>
- iii. Although the provider is only required to confirm MSP information once every 90 days for recurring services, Medicare continues to have the right of recovery on claims paid incorrectly due to the existence of a primary payer. <Medicare Secondary Payer Manual, Chapter 3 § 20.1 (2)>
- c. Beneficiaries Covered by a Medicare Advantage Plan
 - i. Providers are not required to collect or report MSP information for beneficiaries who are enrolled in a Medicare Advantage Plans. <Medicare Secondary Payer Manual, Chapter 3 § 20.1 3.>

4. Retirement Date for MSP Purposes

- a. If the beneficiary cannot recall the precise date of their or their spouse's retirement as it relates to coverage under a GHP, the provider should report the retirement date as follows:
 - i. If the beneficiary knows the applicable retirement date was prior to their Medicare entitlement date, as shown on their Medicare card, the provider should report the Medicare entitlement date as the retirement date. <Medicare Secondary Payer Manual, Chapter 3 § 20.1 4.>
 - ii. If the beneficiary knows the applicable retirement date was after their Medicare entitlement date and was at least 5 years prior to the date of service or admission, the provider should report the date exactly 5 years prior to the date of service or admission as the retirement date. <Medicare Secondary Payer Manual, Chapter 3 § 20.1 4.>
 - iii. If the beneficiary knows the applicable retirement date was after their Medicare entitlement date but was less than 5 years prior to the date of service or admission, the provider must obtain the retirement date from an appropriate source (e.g., the beneficiary's former employer or supplemental insurer). <Medicare Secondary Payer Manual, Chapter 3 § 20.1 4.>

VII. Rules for Determining Payers Primary to Medicare

A. Rules for GHPs and Large GHP (LGHP)

1. A GHP is any arrangement by one or more employers or employee organizations (such as a union) to provide health care, directly or through other methods such as insurance or reimbursement, to current or former employees or others

associated with the employer in a business relationship, or their families. <42 C.F.R. § 411.101>

The term GHP includes self-insured plans, plans of government entities (Federal, State, and local), employee organization plans such as union plans, employee health and welfare funds, other employee organization plans, and employee-pay-all plans under the auspices of one or more employers or employee organizations with no contribution from the employer or organization.

2. The following three groups of Medicare beneficiaries are affected by MSP GHP provisions differently: “Working aged”, disabled individuals, and individuals with End-Stage Renal Disease (ESRD).

- a. “Working Aged” (Beneficiaries Currently Employed)

- i. Medicare is secondary coverage to a GHP if all the following are true:

- a) The beneficiary is age 65 or older and entitled to Medicare due to age;
 - b) The insured person under the GHP is the beneficiary or the beneficiary’s spouse;

The term spouse includes any spouse of a marriage that is valid in the jurisdiction it was performed.

- c) The GHP coverage is based upon the current employment status of the insured person; and
 - d) The employer has 20 or more employees, or the GHP is part of a multiple employer or multi-employer plan in which at least one participating employer has 20 or more employees participates.
<Medicare Secondary Payer Manual, Chapter 1 § 20.1 and Chapter 2 § 10>

- ii. For more information on the “Working Aged” provisions and counting the 20 employee requirement, see Chapters 1 and 2 of the *Medicare Secondary Payer Manual*.

- b. Disabled Beneficiaries

- i. Medicare is secondary coverage to a LGHP if all the following are true:

- a) The beneficiary is under 65 and entitled to Medicare based on disability;
- b) The insured person is the beneficiary or family member;

The term family member means a person enrolled in a GHP based on another person's enrollment and may include a spouse (including a divorced or common law spouse); a natural, adopted, or foster child; a stepchild; a parent; or a sibling.

- c) The LGHP coverage is based on the current employment status of the insured person; and
- d) The employer providing coverage employs at least 100 employees, or if the LGHP is part of a multiple employer or multi-employer plan in which at least one participating employer employs 100 or more employees. <Medicare Secondary Payer Manual, Chapter 1 § 20.3 and Chapter 2 § 30>
- ii. For more information on the "Working Aged" provisions and counting the 100 employee requirement, see Chapters 1 and 2 of the *Medicare Secondary Payer Manual*.
- c. Individuals with ESRD
 - i. Medicare is secondary coverage to a GHP if all of the following are true:
 - a) The beneficiary is on Medicare solely due to ESRD;
 - b) The beneficiary is covered by a GHP; and
 - c) The beneficiary is within the 30-month coordination period. <Medicare Secondary Payer Manual, Chapter 1 § 20.2 and Chapter 2 §§ 20, 20.1>
 - 1) The 30-month coordination period begins with the first month the individual becomes entitled to enroll in Medicare because of ESRD, regardless of whether enrollment is delayed, or the individual chooses not to enroll. <Medicare Secondary Payer Manual, Chapter 2 § 20, 20.1, 20.1.1>
 - ii. There are special rules for beneficiaries who have dual entitlement/eligibility for Medicare coverage (i.e., entitlement based on ESRD and also based on age or disability). More information is available in the

Medicare Secondary Payer Manual, Chapter 2 § 20.1.3 and Chapter 2 § 20.2.

B. Non-Group Health Plan Coverage

1. Medicare is secondary coverage if medical bills are related to an injury from an accident or incident for which a NGHP payer is responsible. <42 C.F.R. §§ 411.20, 411.40, and 411.50>
2. NGHP coverage includes three different types of insurance: liability, no-fault and worker's compensation. <42 C.F.R. § 411.20>
 - a. Liability insurance provides payment based on an individual's legal liability for injury or illness, including automobile insurance, uninsured/underinsured motorist insurance, homeowner's liability insurance, malpractice insurance, product liability insurance, and general casualty insurance, including self-insured plans. <42 C.F.R. § 411.50>
 - b. No-fault insurance pays for medical expenses for injuries sustained on the property or premises of the insured or in the use, occupancy, or operation of an automobile, regardless of who is responsible for the accident (i.e., who is at fault). <42 CFR § 411.50>

No-fault liability insurance is sometimes called “medical payments coverage”, “personal injury protection”, or “medical expense coverage”.

- c. Worker's compensation coverage includes coverage under the worker's compensation plans of the 50 States, the District of Columbia, American Samoa, Guam, Puerto Rico, and the Virgin Islands, as well as coverage under the Federal Employee's Compensation Act and the Longshoremen's and Harbor Worker's Compensation Act. <42 C.F.R. § 411.40>

VIII. Conditional Payments and Set Aside Arrangements for NGHPs

A. Conditional Payments

1. If a NGHP does not pay or does not pay promptly, Medicare may make conditional payment, with the condition of reimbursement to the program if payment is made from a primary payer. <42 CFR 411.45 and 411.52; *Medicare Secondary Payer Manual*, Chapter 1 § 20.7, Chapter 2 § 40, and Chapter 3 §§ 30.2.1.1, and 30.2.1.2>
 - a. Prompt payment from a liability insurer is payment within 120 days of:
 - i. The claim being filed with the insurer;

- ii. A lien being filed against a liability settlement;
 - iii. The date of service or of discharge for an inpatient admission. <42 CFR 411.21; *Medicare Secondary Payer Manual*, Chapter 1 § 20.7, Chapter 2 §§ 40.2 B, 60>
- b. Upon expiration of the prompt payment period, the hospital may either:
- i. Withdraw all claims and liens against the liability insurance and settlement, except for services not covered by Medicare and Medicare deductibles and coinsurance, and bill Medicare for conditional payment; or
 - ii. Maintain their claim and/or lien against the liability insurance/settlement. <*Medicare Secondary Payer Manual*, Chapter 2 § 40.2 B>
 - iii. There are special rules for Oregon providers related to a court order in Oregon. Oregon providers should seek counsel on their options if a liability insurer does not pay within 120 days. <*Medicare Secondary Payer Manual*, Chapter 2 § 40.2 C>
- c. Conditional payment is requested by using occurrence code 24 with the date of denial of payment and the appropriate value code representing the applicable NGHP and entering a zero for the amount. <*Medicare Secondary Payer Manual*, Chapter 3 § 30.2.1.1>
- i. See Attachment A for a summary of MSP billing codes.

B. Medicare Set Aside (MSA) Arrangements

1. A MSA is a financial arrangement that allocates a portion of a settlement, judgment, or award for payment of future medical expenses. It's a formal method to preserve funds from the settlement to pay for future medical expenses that would be covered by Medicare. <*MLN Matters SE17019*>
 - a. The MSA must be exhausted before Medicare will pay for treatment related to the illness, injury or disease that was the subject of the settlement. <*MLN Matters SE17019*>
 - b. There are three types of MSAs recognized in the CWF:
 - i. Worker's Compensation MSA (WCMSA) for funds set aside from a worker's compensation settlement. CMS published a "WCMSA Reference Guide" and other resources for beneficiaries and their attorneys' on their website. <CMS.gov, "Workers' Compensation Medicare Set Aside Arrangements">

- ii. Liability MSA (LMSA) for funds set aside from a settlement from a liability policy or plan (including self-insured plan). <Medicare One Time Notification Transmittal 1787>
- iii. No-fault MSA (NFMSA) for funds set aside from a liability settlement from a no-fault or auto insurance policy. <Medicare One Time Notification Transmittal 1787>
- c. The HIPAA Eligibility Transaction System (HETS) returns the MSP Qualifier LT (Litigation) if the patient has a LMSA and AP (Auto Policy) if the patient has a NFMSA. <Medicare One Time Notification Transmittal 1787, Business Requirements 9893.19.1, 9893.19.2>
- d. The patient should inform providers they have a MSA, and providers should bill and accept payment directly from the patient out of the MSA funds as long as the services are related to the settlement and would normally be covered by Medicare. <MLN Matters SE17019>
- e. The MAC may override the CWF MSP edits for the presence of an MSA if the diagnosis codes for a claim are not related to the diagnosis for the settlement MSA. <Medicare One Time Notification Transmittal 1787, Business Requirement 9893.16>
- f. If MSA funds are exhausted during a patient stay or do not fully cover a claim from a provider, the claim will be processed for residual Medicare payment based on the amount of payment from the primary payer. <Medicare One Time Notification Transmittal 1787, Business Requirement 9893.16.1.1, Medicare Secondary Payer Manual Transmittal 113>

IX. Medicare Claims Flow and Processing Systems for Hospitals

- A. Medicare claims flow through 3 primary systems during processing. <MLN Matters Article SE0605>
 - 1. The MAC's Claims Processing System.
 - a. System resides at the MAC level.
 - i. The MAC generates responses to providers and beneficiaries for submitted claims. <MLN Matters Article SE0605>
 - 2. The "Fiscal Intermediary Shared System" (FISS).
 - a. The FISS processes institutional provider claims passing from the MAC systems. Two other "shared systems" process supplier (professional) and DME claims. <MLN Matters Article SE0605>

- i. The FISS processes hospital Part A and Part B claims, using the inpatient and outpatient PRICER, the inpatient GROUPER, fee schedules, coding tables, the IOCE and MCE supplied by CMS.
- 3. The Common Working File (CWF)
 - a. The Common Working File contains beneficiary specific information.
 - i. The CWF serves to verify entitlement to Medicare, deductible status, benefit days, Medicare Secondary Payor issues, and eligibility for frequency limited services. <MLN Matters Article SE0605>

B. How do the Systems Fit Together

- 1. Handout 7 is a chart mapping the Medicare Claims Processing Systems from *MLN Matters Article SE0605*.

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ATTACHMENT A
Summary of Codes used in MSP Billing

All MSP situations	<p><u>Condition Codes:</u> 08: Beneficiary refuses to provide information on other insurance coverage 77: Payment accepted by primary payer as payment in full (by obligation or law) D7: Reason code for adjustment to make Medicare the secondary payer D8: Reason code for adjustment to make Medicare the primary payer</p> <p><u>Occurrence Codes:</u> 24: Date higher priority payer denied coverage, reason for denial is noted in the Remarks field 25: Date higher priority payer terminated coverage</p> <p><u>Value Codes:</u> 44: Amount provider agreed to accept as payment in full, if less than charges and higher than payment actually received</p> <p><u>Form Locators:</u> 58A, B, C: Name of insured 59A, B, C: Patient's Relationship to insured 60A, B, C: Health plan ID number 61A, B, C: Insurance Group Name 62A, B, C: Insurance Group Number</p>
Worker's Compensation/ Employment related (include black lung)	<p><u>Condition Codes:</u> 02: Employment Related 05: Lien filed</p> <p><u>Occurrence Codes:</u> 04: Date of work-related accident</p> <p><u>Value Codes:</u> 15: Amount of payment by higher priority WC payer, 000000 entered if requesting conditional payment</p> <p>41: Amount of payment by black lung benefit, 000000 entered if requesting conditional payment because of failure to promptly pay</p>

No-fault Insurance	<p><u>Condition Codes:</u> 05: Lien filed</p> <p><u>Occurrence Code:</u> 01: Date of auto accident 02: Date of accident – where state has no-fault laws that provide for settlement w/o admission of liability 05: Date of accident, no no-fault or liability coverage</p> <p><u>Value Codes:</u> 14: Amount of payment by higher priority no-fault payer, 000000 entered if requesting conditional payment because of failure to promptly pay</p>
Third Party Liability	<p><u>Condition Codes:</u> 05: Lien filed</p> <p><u>Occurrence Code:</u> 01: Date of auto accident 03: Date of accident with third party liability, includes civil court action to hold party liable 05: Date of accident, no no-fault or liability coverage</p> <p><u>Value Codes:</u> 47: Amount of payment by higher priority liability insurer, 000000 entered if requesting conditional payment because of failure to promptly pay</p>
Working Aged (covered by GHP)	<p><u>Condition Codes:</u> 09: Neither patient nor spouse is employed 28: Patient or spouse GHP is secondary to Medicare (employer has less than 20 employees)</p> <p><u>Occurrence Codes:</u> 18: Date of retirement 19: Date of spouse's retirement A1, B1, C1: Birth date of insured in whose name the insurance is carried A2, B2, C2: Effective date of other insurance A3, B3, C3: Date after which benefits are terminated or exhausted</p> <p><u>Value Codes:</u> 12: Amount of payment by higher priority employee GHP, 000000 entered if requesting conditional payment because of denied coverage</p>

ESRD (covered by GHP)	<p><u>Condition Codes:</u> 06: Beneficiary in 30-month Medicare Coordination period and covered by GHP 09: Neither patient nor spouse is employed</p> <p><u>Occurrence Codes:</u> 18: Date of retirement 19: Date of spouse's retirement 33: Date of start of coordination period, covered by GHP A1, B1, C1: Birth date of insured in whose name the insurance is carried A2, B2, C2: Effective date of other insurance A3, B3, C3: Date after which benefits are terminated or exhausted</p> <p><u>Value Codes:</u> 13: Amount of payment by higher priority employee GHP, 000000 entered if requesting conditional payment because of denied coverage</p>
Disabled (covered by GHP)	<p><u>Condition Codes:</u> 09: Neither patient nor spouse is employed 11: Disabled Beneficiary, no GHP 29: Patient or family member GHP is secondary to Medicare (employer has less than 100 employees)</p> <p><u>Occurrence Codes:</u> 18: Date of retirement 19: Date of spouse's retirement A1, B1, C1: Birth date of insured in whose name the insurance is carried A2, B2, C2: Effective date of other insurance A3, B3, C3: Date after which benefits are terminated or exhausted</p> <p><u>Value Codes:</u> 43: Amount of payment by higher priority employee GHP, 000000 entered if requesting conditional payment because of denied coverage</p>
Public Health Services, other Federal Agency, or Veteran's Administration	<p><u>Value Codes:</u> 16: Amount of payment by higher priority government payer, 000000 entered if requesting conditional payment because of substantial delay 42: Amount of payment by veterans' administration applied to charges</p>

CASE STUDIES WITH ANALYSIS

Case Study 1

Facts: A patient presents to the emergency department with chest pain (R07.9). Following testing, including an EKG and cardiac enzymes, the patient is diagnosed with a recurrence of Gastroesophageal Reflux Disease (GERD) (K21.0). What diagnosis or diagnoses codes should be reported on the claim and in what field or fields?

Analysis: The GERD (K21.0) should be reported in FL 67 Principal/First Listed Diagnosis Code. The chest pain (R07.9) must also be reported in FL 70 Patient Reason for Visit because this was an emergency visit and a Patient Reason for Visit must be reported on emergency department visits. The chest pain further provides the justification for the cardiac related tests, even though the final diagnosis for the patient was GERD. <Medicare Claims Processing Manual, Chapter 25 § 75.6>

Case Study 2

Facts: A hospital provided a diagnostic test on September 15, 2023, submitted a claim for the test on November 15, 2023, and received a denial for the test on December 1, 2023. How long does the hospital have to submit an adjustment request? A reopening?

Analysis: The hospital has until September 14, 2024, to submit an adjustment claim and until December 1, 2024 to submit a reopening or December 1, 2027 with good cause.
<MLN Matters Article SE1426>

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Billing Requirements for OPPS Providers with Multiple Service Locations

MLN Matters Number: SE18002

Related Change Request (CR) Number: 9613; 9907

Related CR Release Dates: August 5, 2016;
February 5, 2017

Effective Date: January 1, 2017

Related CR Transmittal Numbers:
R1704OTN and R1783OTNImplementation Date: January 3, 2017 for
CR9613 and July 3, 2017 for CR9907

PROVIDER TYPES AFFECTED

This MLN Matters® Special Edition Article is intended for Outpatient Prospective Payment System (OPPS) providers that have multiple service locations submitting claims to Medicare A/B Medicare Administrative Contractors (MACs).

WHAT YOU NEED TO KNOW

This article conveys enforcement editing requirements for the Medicare Claims Processing Manual, Chapter 1, and Section 170 which describes Payment Bases for Institutional Claims. These requirements are not new requirements. Previously, these requirements were discussed in CRs 9613 and 9907, both of which were effective on January 1, 2017. MLN Matters articles for CRs 9613 and 9907 are available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9613.pdf> and <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9907.pdf>, respectively. Make sure your billing staff is aware of these instructions.

BACKGROUND

Increasingly, hospitals operate off-campus, outpatient, provider-based department of a hospital's facilities. In some cases, these additional locations are in a different payment locality than the main provider. In order for Medicare Physician Fee Schedule (MPFS) and OPPS payments to be accurate, the service facility address of the off-campus, outpatient, provider-based department of a hospital facility is used to determine the locality in these cases.

Additionally, in accordance with Section 1833(t)(21) of the Act, as added by section 603 of the Bipartisan Budget Act of 2015 (Pub. L. 114-74), Non-excepted services provided at an off-

campus, outpatient, provider-based department of a hospital were required to be identified as non-excepted items and services billed on an institutional claim and to be paid under the MPFS and not the OPFS rates.

Claim level information:

Medicare outpatient service providers report the service facility location for off-campus, outpatient, provider-based department of a hospital facilities in the 2310E loop of the 837 institutional claim transaction. Direct Data Entry (DDE) submitters also are required to report the service facility location for off-campus, outpatient, provider-based department of a hospital facilities. Paper submitters report the service facility address information in Form Locator (FL) "01" on the paper claim form. For MPFS services, Medicare systems use this service facility information to determine the applicable payment method or locality whenever it is present.

Additionally, Medicare systems will validate service facility location to ensure services are being provided in a Medicare enrolled location. The validation will be exact matching based on the information submitted on the Form CMS-855A submitted by the provider and entered into the Provider Enrollment, Chain and Ownership System (PECOS). Providers need to ensure that the claims data matches their provider enrollment information.

When all the services rendered on the claim are from the billing provider address, providers are:

- To report the billing provider address only in the billing provider loop and not to report any service facility location.

When all the services rendered on the claim are from one campus of a multi-campus provider that report a billing provider address, providers are:

- To report the campus address where the services were rendered in the service facility location if the service facility address is different from the billing provider address.

When all the services rendered on the claim are from the same off-campus, outpatient, provider-based department of a hospital facilities, providers are:

- To report the off-campus, outpatient, provider-based department service facility address in the service facility provider loop.

When there are services rendered on the claim from multiple locations:

- If any services on the claim were rendered at the billing provider address, providers should report the billing provider address only in the billing provider loop 2010AA and do not report the service facility location in loop 2310E.

- If no services on the claim were rendered at the billing provider address, providers should report the service facility address from the first registered encounter of the “From” date on the claim.

NM1 - SERVICE FACILITY LOCATION NAME – 60 Characters 837I – 25, UB-04**N3 - SERVICE FACILITY LOCATION ADDRESS****N301 – 55 Characters 837I – 25 Characters on the UB-04****N302 – 55 Characters 837I – not on UB-04 paper form****N4 - SERVICE FACILITY LOCATION CITY, STATE, ZIP CODE****N401 City Name – 30 Characters 837I – 12 Characters on the UB-04****N402 State Code – 2 Characters 837I – 2 Characters on the UB-04****N403 Postal Code – 15 Characters 837I – 9 Characters on the UB-04****Line level information:**

In the CY 2015 OPPI Final Rule (79 FR 66910-66914), the Centers for Medicare & Medicaid Services (CMS) created a HCPCS modifier for hospital claims that is to be reported with each claim line with a HCPCS for outpatient hospital items and services furnished in an off-campus provider-based department (PBD) of a hospital. This 2-digit modifier was added to the HCPCS annual file as of January 1, 2015, with the label “PO.” Reporting of this new modifier was voluntary for CY 2015, with reporting required beginning on January 1, 2016.

In accordance with Section 1833(t)(21) of the Act, as added by section 603 of the Bipartisan Budget Act of 2015 (Pub. L. 114-74), CMS established a new modifier “PN” (Non-excepted service provided at an off-campus, outpatient, provider-based department of a hospital) to identify and pay non-excepted items and services billed on an institutional claim. Effective January 1, 2017, non-excepted off-campus provider-based departments of a hospital are required to report this modifier on each claim line with a HCPCS for non-excepted items and services. The use of modifier “PN” will trigger a payment rate under the MPFS. CMS expects the PN modifier to be reported with each non-excepted line item and service including those for which payment will not be adjusted, such as separately payable drugs, clinical laboratory tests, and therapy services; with reporting required beginning on January 1, 2017.

As a result, effective January 1, 2017, excepted off-campus provider-based departments of a hospital must continue to report existing modifier “PO” (Services, procedures and/or surgeries provided at off-campus provider-based outpatient departments) for all excepted items and services with a HCPCS furnished.

Billing Examples

No.	Service Facility	Billing Provider	Service Facility Address	Modifier Used
1	Billing provider (Main Campus) Only	Yes	N/A	No "PO" or "PN" Modifier required on billing provider services.
2	Billing Provider (Main Campus), Excepted Off-Campus	Yes	N/A	No "PO" or "PN" Modifier required on Main Campus services. Modifier "PO" required on services with a HCPCS from Excepted Off-Campus.
3	Billing Provider (Main Campus), Non-Excepted Off-Campus	Yes	N/A	No "PO" or "PN" Modifier required on Main Campus services. Modifier "PN" required on services with a HCPCS from Non-Excepted Off-Campus.
4	Billing Provider (Main Campus), Campus of Multi-Campus provider*	Yes	N/A	No "PO" or "PN" Modifier required on billing provider services or other Campus services of a Multi-Campus.
5	Campus of Multi-Campus provider*	Yes	Yes Campus Address*	No "PO" or "PN" Modifier required on billing Campus services of a Multi-Campus.
6	Billing Provider (Main Campus), Excepted Off-Campus, Non-Excepted Off-Campus	Yes	N/A	No "PO" or "PN" Modifier required on Billing Provider services. Modifier "PO" required on services with a HCPCS from Excepted Off-Campus. Modifier "PN" required on services with a HCPCS from Non-Excepted Off-Campus.

No.	Service Facility	Billing Provider	Service Facility Address	Modifier Used
7	Billing Provider (Main Campus), Campus of Multi-Campus provider*, Excepted Off-Campus, Non-Excepted Off-Campus	Yes	N/A	No "PO" or "PN" Modifier required on billing provider services or other Campus services of a Multi-Campus. Modifier "PO" required on services with a HCPCS from Excepted Off-Campus. Modifier "PN" required on services with a HCPCS from Non-Excepted Off-Campus.
8	Campus of Multi-Campus provider*, Excepted Off-Campus, Non-Excepted Off-Campus	Yes	Yes Campus Address*	No "PO" or "PN" Modifier required on billing Campus services of a Multi-Campus. Modifier "PO" required on services with a HCPCS from Excepted Off-Campus. Modifier "PN" required on services with a HCPCS from Non-Excepted Off-Campus.
9	Excepted Off-Campus	Yes	Yes	Modifier "PO" required on all services with a HCPCS.
10	Non-Excepted Off-Campus	Yes	Yes	Modifier "PN" required on all services with a HCPCS.
11	Excepted Off-Campus, Non-Excepted Off-Campus	Yes	Yes First Registered Encounter	Modifier "PO" required on services with a HCPCS from Excepted Off-Campus. Modifier "PN" required on services with a HCPCS from Non-Excepted Off-Campus.

No.	Service Facility	Billing Provider	Service Facility Address	Modifier Used
12	Excepted Off-Campus, Excepted Off-Campus	Yes	Yes First Registered Encounter	Modifier "PO" required on all services with a HCPCS.
13	Non-Excepted Off- Campus, Non-Excepted Off- Campus	Yes	Yes First Registered Encounter	Modifier "PN" required on all services with a HCPCS.

* Campus address is different from Billing Provider address; if the Campus address is the same as the Billing Provider address, follow the billing provider instructions.

ADDITIONAL INFORMATION

If you have any questions, please contact your MAC at their toll-free number, which is available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html>.

You may also want to review relevant portions of MLN Matters articles MM9097 and MM9930 at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9097.pdf> and <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9930.pdf>, respectively.

DOCUMENT HISTORY

Date of Change	Description
March 15, 2018	Initial article released.

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Activation of Validation Edits for Providers with Multiple Service Locations

MLN Matters Number: SE19007 **Revised**

Related Change Request (CR) Number: [9613](#); [9907](#)

Revised Article Release Date: **December 26, 2023** Effective Date: N/A

Related CR Transmittal Numbers: R1704OTN; Implementation Date: N/A
R1783OTN

What's Changed: We clarified these instructions don't apply to separately enrolled provider-based rural health clinics and added information on the 09/23 version of the paper-based enrollment form. Substantive changes are in dark red on pages 1-2.

Affected Providers

- Hospitals
- Other providers with multiple service locations submitting Outpatient Prospective Payment System (OPPS) claims to Medicare Administrative Contractors (MACs)

What You Need to Know

This Article tells you about enforcing the systematic validation edits requirements in Section 170 of the [Medicare Claims Processing Manual](#), Chapter 1. These aren't new requirements. CMS discussed these requirements in CRs 9613 and 9907, effective January 1, 2017. On March 24, 2020, we announced a delay until further notice to the activation of these for OPPS providers with multiple service locations. Make sure your billing staff knows of these instructions.

Background

Increasingly, hospitals operate an off-campus, outpatient, provider-based department of a hospital. In some cases, these additional locations are in a different payment locality than the main provider. For Physician Fee Schedule (PFS) and OPPS payments to be accurate, we use the service facility address of the off-campus, outpatient, provider-based department of a hospital facility to decide the locality in these cases. **(These instructions don't apply to separately enrolled provider-based rural health clinics. See Section 10.2.1.13, IOM 100-08, [Chapter 10](#), Rural Health Clinics (RHCs), for information on separately enrolling provider-based RHCs.)**

Under Section 1833(t)(21) of the [Social Security Act](#), you must identify non-excepted services at

an off-campus, outpatient, provider-based department of a hospital. We'll pay for non-excepted items and services you bill on an institutional claim under the PFS and not the OPPS rates.

Enrollment Information

To verify enrollment, active practice locations should:

- Access the direct data entry (DDE) Provider Practice Address Query - Option 1D
- Review current Medicare information on [PECOS](#)

To add a new or revise an existing location, complete a change of information enrollment application 1 of these ways:

- Online through PECOS [pecos.cms.hhs.gov]
- Paper-based [Medicare Enrollment Application - Institutional Providers \(CMS-855A\)](#)

For PECOS, in the hospital practice location section, make sure you identify the appropriate type of practice location. If your practice location type isn't listed, mark "Other Hospital Practice Location" and **enter the correct type in the free-form field** (for example, on-campus, remote location, emergency department, 603 exception, non-OPPS department, mobile facility and/or portable units, off-campus department **(the 09/23 version of the paper-based form contains these types of practice locations separately listed)**). Use these definitions when entering your location or facility:

1. **On Campus:** The physical area immediately adjacent to the provider's main buildings, other areas, and structures that aren't strictly contiguous to the main building, but are located within 250 yards on the main buildings, and any other areas determined on an individual case basis to be part of the provider's campus. Hospital provider fulfills the obligations of hospital outpatient department.
2. **Remote Location of a Hospital:** A facility or organization that's either created by or acquired by a hospital that's the main provider for the purpose of providing inpatient hospital services under the name, ownership, and financial and administrative control of the main provider. A remote location of a hospital comprises both the specific physical facility that serves as the site of service of which separate payment could be claimed under the Medicare Program, and the personnel and equipment needed to deliver the services at the facility. The Medicare conditions of participation (CoPs) don't apply to a remote location of a hospital as an independent entity, per [42 CFR 413.65\(a\)\(2\)](#).
3. **Emergency Department:** Per [42 CFR 489.24\(b\)](#), a provider-based off-site hospital emergency department (ED) must demonstrate compliance with the hospital CoPs. They must also comply with the provider-based regulations at 42 CFR 413.65. A department or location can't be both an urgent care center and an ED unless they're distinct and separate — at a minimum, they must have different suite numbers.

4. **603 Exception Department:** Grandfathered by mid-build legislation or provider-based department (PBD) that relocates to a new location (either temporarily or permanently), without losing its excepted status, upon a demonstration of extraordinary circumstances outside of the hospital's control, such as natural disasters, significant seismic building code requirements, or significant public health and public safety issues.
5. **Non-OPPS Department:** The practice location is a non-OPPS location. Rural emergency hospital (REH); opioid treatment program (OTP); therapy; ESRD; certain hospitals in Maryland that are paid under Maryland waiver provisions; Critical Access Hospitals (CAHs); Indian Health Service hospitals; hospitals located in American Samoa, Guam, and Saipan; and hospitals located in the Virgin Islands.
6. **Mobile Facility and/or Portable Units:** Practice location is a mobile facility or portable unit.
7. **Off-Campus Department:** The practice facility isn't located on the campus of the main provider (greater than 250 yards), and the hospital provider fulfills the obligations of hospital outpatient department.

In the PECOS system, use the screen below to enter "Other Hospital Practice Location". You must:

- Select "Other Health Care Facility"

* This location is a: Select Apply

* Other Health Care Facility (Specify): Select

Cancel

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- Fill the free form field with either on-campus, remote location, emergency department, 603 exception, non-OPPS department, mobile facility and/or portable units, or off-campus department

* This location is a: Other Health Care Facility Apply

* Other Health Care Facility (Specify):

Claim Information

Claim Level:

You must report the service facility location for an off-campus, outpatient, provider-based department of a hospital in the 2310E loop of the 837 institutional claim transaction.

Line-Level:

When you report a service facility address on your claim, you must also report the appropriate modifier (for example, PO, PN, ER) with each claim line that includes a HCPCS code for a service provided at an off-campus PBD. Don't report more than 1 of these modifiers (PO, PN, or ER) on the same claim line. In addition, the modifier you report must correspond with the hospital practice location type identified in PECOS.

DDE submitters report the service facility location for an off-campus, outpatient, provider-based department of a hospital. Paper submitters report the service facility address information in Form Locator (FL) "01" on the paper claim form. For PFS services, Medicare systems use this service facility information to decide the applicable payment method or locality whenever it's present.

Medicare systems will validate service facility location to make sure you're providing services in a Medicare-enrolled location. The validation will be exact matching based on the information on the Form CMS-855A you submitted to PECOS. Make sure your claims data matches your PECOS data.

When you provide services on a claim from the billing provider address:

- Report the billing provider address only in the billing provider loop 2010AA
- Don't report any service facility location in loop 2310E — or in DDE MAP 171F screen for DDE submitters

When you provide services on a claim from 1 campus of a multi-campus provider that reports a billing provider address:

- Report the campus address where you provided the services in the service facility location in loop 2310E if the service facility address is different from the billing provider address loop 2010AA
- Use DDE MAP 171F screen for DDE submitters

When you provide services on a claim from the same off-campus, outpatient, provider-based, department of a hospital:

- Report the off-campus, outpatient, provider-based department service facility address in the service facility provider loop 2310E
- Use DDE MAP 171F screen for DDE submitters

When you provide services on a claim at multiple locations:

- If you provide any services on the claim at the billing provider address, report the billing provider address only in the billing provider loop 2010AA, and don't report the service

facility location in loop 2310E — or in DDE MAP 171F screen for DDE submitters

- If you provide any services on the claim at more than 1 of the campus locations of a multi-campus provider that isn't the main billing provider address, report the service facility address in loop 2310E if all of the service facility addresses are different from the billing provider address in loop 2010AA — or in DDE MAP 171F screen for DDE submitters — from the first registered campus encounter of the "From" date on the claim
- If you provide any services on the claim at 1 of the campus locations of a multi-campus provider that isn't the main billing provider address and you also provide services on the claim at other off-campus department practice locations, report the campus address where you provided the services in the service facility location in loop 2310E if the service facility address is different from the billing provider address in loop 2010AA — or in DDE MAP 171F screen for DDE submitters
- If you provide no services on the claim at the billing provider address or any campus location of a multi-campus provider, report the service facility address in loop 2310E — or in DDE MAP 171F screen for DDE submitters — from the first registered department practice location encounter of the "From" date on the claim

National Testing

Round 1 Testing

During the week of July 23 - 30, 2018, we did a national trial activation of the FISS Edits 34977 and 34978 in production environments. We activated Reason Codes 34977 (claim service facility address doesn't match provider practice file address) and 34978 (Off-campus provider claim line that contains a HCPCS must have a PN or PO). The testing was transparent to you, as we suspended most claims impacted by the test for 1 billing cycle and then we turned editing off so the claim could continue processing as normal.

This national test showed that many providers aren't sending the correct exact service facility location on the claim that produces an exact match with the Medicare-enrolled location entered into PECOS for their off-campus provider departments.

Most discrepancies had to do with spelling variations. For example, in PECOS, the word you entered was "Road" as part of your address, but you entered "Rd" or "Rd." as part of the address on the claim submission. Another example, in PECOS the word entered was "STE" as part of the address, but you entered "Suite" as part of your address on the claim submission.

Round 2 Testing

Make sure all practice locations are present in PECOS and if any locations aren't in PECOS, submit the 855A to add the location. You can review your practice locations in PECOS or in the confirmation letter from PECOS when you last added a location to see if your service facility address for the off-campus provider department locations you put on your claim is an exact match.

Round 3 Testing

Version 033
Check for Updates


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MAP1AB2 ..... /.../...
..... SC .. PROVIDER PRACTICE ADDRESS QUERY ..... MNT: .....

.....
NPI ..... OSCAR .....

PRAC EFF DT ..... PRAC TERM DT .....
PRACTICE LOCATION KEY .....
OTHER PRACTICE ..
TYPE OF PRACTICE

.....
ADDRESS 1 .....
ADDRESS 2 .....
CITY ..... STATE .. ZIP .....
NPI EFF DT ..... NPI TERM DT .....

```

Round 3 Testing Update & Full Production Delayed

We completed round 3 testing. We decided to postpone full production implementation until further notice. Once we implement full production, we'll turn on the edits permanently and set them to RTP claims that don't exactly match. You can make corrections to your service facility address for a claim submitted in the DDE MAP 171F screen for DDE submitters. If you need to add a new or correct an existing practice location address, you'll need to submit a new 855A enrollment application in PECOS.

Round 4 Testing Update & Full Production Delayed Due to COVID-19

We postponed full production implementation due to the COVID-19 public health emergency (PHE).

Round 5 Testing

We did another round of testing in May 2023 after the PHE ended to make sure we have a smooth implementation of the edits. We did this testing to make sure providers have used the new practice location screen tool and made necessary claims submission updates to their systems and were prepared for implementation of the edits after the end of the PHE.

Round 5 Testing Update & Full Production

During Round 5 testing, overall claim volume for Reason Codes 34977 (claim service facility address doesn't match provider practice file address) and 34978 (Off-campus provider claim line that contains a HCPCS must have a PN or PO) trended downward. We didn't identify any new issues during Round 5 Testing.

On August 1, 2023, we'll start deploying editing into full production and we've told the MACs to develop implementation plans to permanently turn on the Reason Codes and set them up to RTP claims that don't exactly match. Your MAC will notify you of their implementation plans.

You can make corrections to your service facility address for a claim submitted and editing reveals the claim has typographical errors that don't match the official postal address in PECOS and in the DDE MAP 171F screen for DDE submitters. If you need to add a new practice location that hasn't been enrolled or correct an existing practice location address that's changed since initial enrollment, you'll still need to submit a new 855A enrollment application in PECOS.

We expect that the almost 7-year time frame that the edits haven't been active gave you ample time to validate your claims submission system and the PECOS information for your off-campus provider departments are exact matches.

More Information

For more information, [find your MAC's website](#).

Document History

Date of Change	Description
December 26, 2023	We clarified these instructions don't apply to separately enrolled provider-based rural health clinics and added information on the 09/23 version of the paper-based enrollment form. Substantive changes are in dark red on pages 1-2.
December 7, 2023	We added information on how to verify and update service locations for Medicare enrollment and what claim modifier to use. Substantive changes are in dark red on pages 1-4.
August 16, 2023	We added new information about the practice location address screen for round 3 testing. Substantive changes are in dark red on pages 3 and 4.
July 11, 2023	We added information on Round 5 testing and national implementation of edits.
March 24, 2020	We revised the article to announce a delay until further notice to the activation of Systematic Validation Edits for OPPS Providers with Multiple Service Locations.
September 5, 2019	We revised the article to announce a delay of full implementation until April 2020.
June 28, 2019	We revised this article to provide an update on Round 3 testing and to announce a delay of full implementation until October 2019.
March 26, 2019	Initial article released.

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Revenue Codes with Status Indicator F or N (Data_Revenue, Column E "STATUS_INDICATOR")

REVENUE _CODE	LO_ VERS	HI_ VERS	DESCRIPTION	STATUS_ INDICATOR
964	92	94	Professional Fees (Also See 097x and 098x) - Anesthetist (CRNA)	F
240	92	94	All Inclusive Ancillary - General Classification	N
250	67	94	Pharmacy (Also See 063x, An Extension of 025x) - General Classification	N
251	67	94	Pharmacy (Also See 063x, An Extension of 025x) - Generic Drugs	N
252	67	94	Pharmacy (Also See 063x, An Extension of 025x) - Non-generic Drugs	N
254	67	94	Pharmacy (Also See 063x, An Extension of 025x) - Drugs Incident to Other	N
255	67	94	Pharmacy (Also See 063x, An Extension of 025x) - Drugs Incident to Radiology	N
257	67	94	Pharmacy (Also See 063x, An Extension of 025x) - Non-prescription	N
258	67	94	Pharmacy (Also See 063x, An Extension of 025x) - IV Solutions	N
259	67	94	Pharmacy (Also See 063x, An Extension of 025x) - Other Pharmacy	N
260	67	94	IV Therapy - General Classification	N
261	67	94	IV Therapy - Infusion Pump	N
262	67	94	IV Therapy - IV Therapy/pharmacy Svcs	N
263	67	94	IV Therapy - IV Therapy/Drug/Supply/ Delivery	N
264	67	94	IV Therapy - IV Therapy/Supplies	N
269	67	94	IV Therapy - Other IV Therapy	N
270	67	94	Medical/Surgical Supplies and Devices (Also See 062x, An Extension of 02	N
271	67	94	Medical/Surgical Supplies and Devices (Also See 062x, An Extension of 02	N
272	67	94	Medical/Surgical Supplies and Devices (Also See 062x, An Extension of 02	N
273	67	94	Medical/Surgical Supplies and Devices (Also See 062x, An Extension of 02	N
275	92	94	Medical/Surgical Supplies and Devices (Also See 062 X, An Extension of 0	N
276	92	94	Medical/Surgical Supplies and Devices (Also See 062x, An Extension of 02	N
278	92	94	Medical/Surgical Supplies and Devices (Also See 062x, An Extension of 02	N
279	67	94	Medical/Surgical Supplies and Devices (Also See 062x, An Extension of 02	N
280	67	94	Oncology - General Classification	N
289	67	94	Oncology - Other Oncology	N
290	67	94	Durable Medical Equipment (Other Than Renal) - General Classification	N
343	92	94	Nuclear Medicine - Diagnostic Radiopharmaceuticals	N
344	92	94	Nuclear Medicine - Therapeutic Radiopharmaceuticals	N
370	67	94	Anesthesia - General Classification	N
371	67	94	Anesthesia - Anesthesia Incident to Radiology	N
372	67	94	Anesthesia - Anesthesia Incident to Other DX Services	N
379	67	94	Anesthesia - Other Anesthesia	N
390	67	94	Administration, Processing, and Storage for Blood and Blood Component:	N
392	67	94	Administration, Processing, and Storage for Blood and Blood Component:	N
399	67	94	Administration, Processing, and Storage for Blood and Blood Component:	N
621	67	94	Medical/Surgical Supplies and Devices - Extension of 027x - Supplies Inci	N
622	67	94	Medical/Surgical Supplies and Devices - Extension of 027x - Supplies Inci	N
623	92	94	Medical/Surgical Supplies and Devices - Extension of 027x - Surgical Dres:	N
624	67	94	Medical/Surgical Supplies and Devices - Extension of 027x - FDA Investiga	N
630	67	94	Reserved for National Assignment	N
631	67	94	Pharmacy - Extension of 025x - Single Source Drug	N
632	67	94	Pharmacy - Extension of 025x - Multiple Source Drug	N
633	67	94	Pharmacy - Extension of 025x - Restrictive Prescription	N
681	67	94	Trauma Response - Level I Trauma	N
682	67	94	Trauma Response - Level II Trauma	N
683	67	94	Trauma Response - Level III Trauma	N
684	67	94	Trauma Response - Level IV Trauma	N
689	67	94	Trauma Response - Other Trauma Response	N
700	67	94	Cast Room - General Classification	N
710	67	94	Recovery Room - General Classification	N
720	67	94	Labor Room/Delivery - General Classification	N
721	67	94	Labor Room/Delivery - Labor	N
732	92	94	EKG/ecg (Electrocardiogram) - Telemetry	N

Revenue Codes with Status Indicator F or N (Data_Revenue, Column E "STATUS_INDICATOR")

REVENUE _CODE	LO_ VERS	HI_ VERS	DESCRIPTION	STATUS_ INDICATOR
762	67	94	Specialty Services - Observation Hours	N
801	92	94	Inpatient Renal Dialysis - Inpatient Hemodialysis	N
802	92	94	Inpatient Renal Dialysis - Inpatient Peritoneal (Non-CAPPD)	N
803	92	94	Inpatient Renal Dialysis - Inpatient Continuous Ambulatory Peritoneal Dia	N
804	92	94	Inpatient Renal Dialysis - Inpatient Continuous Cycling Peritoneal Dialysis	N
809	92	94	Inpatient Renal Dialysis - Other Inpatient Dialysis	N
810	67	94	Acquisition of Body Components - General Classification	N
815	67	94	Acquisition of Body Components - Stem Cell Acquisition - Allogeneic	N
819	67	94	Acquisition of Body Components - Other Donor	N
821	67	94	Hemodialysis - Outpatient or Home - Hemodialysis Composite or Other R	N
824	67	94	Hemodialysis - Outpatient or Home - Maintenance - 100%	N
825	67	94	Hemodialysis - Outpatient or Home - Support Services	N
829	67	94	Hemodialysis - Outpatient or Home - Other Op Hemodialysis	N
860	92	94	Magnetoencephalography (Meg) - General Classification	N
861	92	94	Magnetoencephalography (MEG) - MEG	N
940	67	94	Other Therapeutic Services (Also See 095x, An Extension of 094x) - Gener	N
942	92	94	Other Therapeutic Services (Also See 095x, An Extension of 094x) - Educa	N
943	67	94	Other Therapeutic Services (Also See 095x, An Extension of 094x) - Cardia	N

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Check for Updates

REVENUE _CODE	LO_ VERS	HI_ VERS	DESCRIPTION	STATUS_ INDICATOR	BYPASS _E48
500	67	94	Outpatient Services - General Classification	Z	1
509	67	94	Outpatient Services - Other Outpatient Service	Z	1
521	67	94	Freestanding Clinic - Clinic Visit by Member to RHC/FQHC	B	1
522	67	94	Freestanding Clinic - Home Visit by RHC/FQHC Practitioner	B	1
524	67	94	Freestanding Clinic - Visit by RHC/FQHC Practitioner to a Member in a SN	B	1
525	67	94	Freestanding Clinic - Visit by RHC/FQHC Practitioner to a Member in a SN	B	1
527	67	94	Freestanding Clinic - Visiting Nurse Service(S) to a Member's Home When	B	1
528	67	94	Freestanding Clinic - Visit by RHC/FQHC Practitioner to Other Non-RHC/F	B	1
583	67	94	Home Health (HH) - Other Visits - Assessment	B	1
637	67	94	Pharmacy - Extension of 025x - Self-Administrable Drugs	E1	1
660	67	94	Respite Care - General Classification	Z	1
661	67	94	Respite Care - Hourly Charge - Nursing	Z	1
662	67	94	Respite Care - Hourly Charge - Aide/Homemaker/Companion	Z	1
663	67	94	Respite Care - Daily Respite Charge	Z	1
669	67	94	Respite Care - Other Respite Care	Z	1
760	67	94	Specialty Services - General Classification	B	1
870	75	94	Cell/Gene Therapy - General Classification	B	1
871	75	94	Cell/Gene Therapy - Cell Collection	B	1
872	75	94	Cell/Gene Therapy - Specialized Biologic Processing and Storage - Prior to	B	1
873	75	94	Cell/Gene Therapy - Storage and Processing After Receipt of Cells From N	B	1
874	75	94	Cell/Gene Therapy - Infusion of Modified Cells	B	1
875	75	94	Cell/Gene Therapy - Injection of Modified Cells	B	1
890	75	94	Pharmacy - Extension of 025x and 063x - Reserved	B	1
891	75	94	Pharmacy - Extension of 025x and 063x - Special Processed Drugs - FDA A	B	1
905	94	94	Behavioral Health Treatment/Services (Also See 091x, An Extension of 09	E1	1
906	67	94	Behavioral Health Treatment/Services (Also See 091x, An Extension of 09	E1	1
907	67	94	Behavioral Health Treatment/Services (Also See 091x, An Extension of 09	E1	1
931	67	94	Medical Rehabilitation Day Program - Half Day	Z	1
932	67	94	Medical Rehabilitation Day Program - Full Day	Z	1
948	67	94	Other Therapeutic Services (Also See 095x, An Extension of 094x) - Pulmc	N	1
990	67	94	Patient Convenience Items - General Classification	E1	1
991	67	94	Patient Convenience Items - Cafeteria/Guest Tray	E1	1
992	67	94	Patient Convenience Items - Private Linen Service	E1	1
993	67	94	Patient Convenience Items - Telephone/telecom	E1	1
994	67	94	Patient Convenience Items - Tv/radio	E1	1
995	67	94	Patient Convenience Items - Non-patient Room Rentals	E1	1
996	67	94	Patient Convenience Items - Late Discharge	E1	1
997	67	94	Patient Convenience Items - Admission Kits	E1	1
998	67	94	Patient Convenience Items - Beauty Shop/Barber	E1	1
999	67	94	Patient Convenience Items - Other Convenience Items	E1	1
1000	67	94	Behavioral Health Accommodations - General Classification	E1	1
1001	67	94	Behavioral Health Accommodations - Residential - Psychiatric	E1	1
1002	67	94	Behavioral Health Accommodations - Residential - Chemical Dependency	E1	1
1003	67	94	Behavioral Health Accommodations - Supervised Living	E1	1
1004	67	94	Behavioral Health Accommodations - Halfway House	E1	1
1005	67	94	Behavioral Health Accommodations - Group Home	E1	1
1006	68	94	Behavioral Health Accommodations - Outdoor/wilderness Behavioral Hea	E1	1
2100	67	94	Alternative Therapy Services - General Classification	E1	1
2101	67	94	Alternative Therapy Services - Acupuncture	E1	1
2102	67	94	Alternative Therapy Services - Acupressure	E1	1
2103	67	94	Alternative Therapy Services - Massage	E1	1
2104	67	94	Alternative Therapy Services - Reflexology	E1	1
2105	67	94	Alternative Therapy Services - Biofeedback	E1	1
2106	67	94	Alternative Therapy Services - Hypnosis	E1	1
2109	67	94	Alternative Therapy Services - Other Alternative Therapy Services	E1	1
3101	67	94	Adult Care - Adult Day Care, Medical and Social - Hourly	E1	1
3102	67	94	Adult Care - Adult Day Care, Social - Hourly	E1	1
3103	67	94	Adult Care - Adult Day Care, Medical and Social - Daily	E1	1
3104	67	94	Adult Care - Adult Day Care, Social - Daily	E1	1
3105	67	94	Adult Care - Adult Foster Care - Daily	E1	1
3109	67	94	Adult Care - Other Adult Care	E1	1

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



MLN Matters® Number: SE1426 Revised

Related Change Request (CR) #: CR 8581

Related CR Release Date: March 16, 2015

Effective Date: Claims received on or after January 1, 2016

Related CR Transmittal #: R3219CP

Implementation Date: January 1, 2016

Scenarios and Coding Instructions for Submitting Requests to Reopen Claims that are Beyond the Claim Filing Timeframes – Companion Information to MM8581: “Automation of the Request for Reopening Claims Process”

Note: This article was revised on May 7, 2015, to make changes to keep the information consistent with the related article, [MM8581](#). The table on page 4 was added, and the effective date and implementation date were also changed. The CR release date, transmittal number and link to the CR also changed to the revised CR for MM8581. All other information remains the same.

Provider Types Affected

This MLN Matters® Article is intended for providers, including home health and hospice providers, and suppliers submitting institutional claims to Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries.

Provider Action Needed

This article is intended to provide additional information, coding instructions and scenarios for requesting a reopening of a claim that is beyond the filing timeframe. It is a companion article to MLN Matters® Article MM8581 (<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8581.pdf>) on the CMS website. MM8581 is based on Change Request (CR) 8581 which informs A MACs about changes that will allow providers and their vendors to electronically request reopening claims. Make sure your billing staffs are aware of these changes.

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Background

When a provider needs to correct or supplement a claim, and the claim remains within timely filing limits, providers may submit an adjustment claim to remedy the error. When the need for a correction is discovered beyond the claims timely filing limit, an adjustment bill is not allowed and a provider must utilize the reopening process to remedy the error.

Generally, reopenings are written requests for corrections that include supporting documentation. However, a standard process across all A/MACs has not been available. In an effort to streamline and standardize the process for providers to request reopenings, CMS petitioned the National Uniform Billing Committee (NUBC) for a “new” bill type frequency code to be used by providers indicating a Request for Reopening and a series of Condition Codes that can be utilized to identify the type of Reopening being requested. These institutional reopenings must be submitted with a “Q” frequency code to identify them as a Reopening. The NUBC adopted these new codes and bill type frequency change effective with claims received on or after January 1, 2016 (based on an October 1, 2015 implementation of ICD-10, see bold below).

A reopening is a remedial action taken to change a final determination or decision that resulted in either an overpayment or an underpayment, even though the determination or decision was correct based on the evidence of record. Reopenings are different from adjustment bills in that adjustment bills are subject to normal claims processing timely filing requirements (that is, filed within one year of the date of service), while reopenings are subject to timeframes associated with administrative finality and are intended to fix an error on a claim for services previously billed (for example, claim determinations may be reopened within one year of the date of the initial determination for any reason, or within one to four years of the date of the initial determination upon a showing of good cause). Note that while the reopening period associated with ARC R1 is one year from the RA date, providers must submit an adjustment bill (TOB xxx7) when the claim correction is submitted within the claims timely filing period (that is, within one year of the date of service or claim through date). The reopening request (TOB xxxQ) should only be utilized when the submission falls outside of the period to submit an adjustment bill.

The following table presents some scenarios of reopening and adjustment timeline scenarios.

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Claim “Through” Date	Remittance Advice (RA) Date	Adjustment Period (based on “Through” date)	Reopening Period – Adjustment Reason Code (ARC)= R1 (Based on RA date after Adjustment Period has lapsed)	Reopening Period – ARC=R2 (Based on RA date)	Reopening Period – ARC=R3 (Based on RA date)
Timely Filing Period – Use TOB xxx7			Beyond Timely Filing Period – Use TOB xxxQ		
10-01-2014	11-01-2014	10-01-2014 Thru 09-30-2015	10-01-2015 Thru 10-31-2015	11-01-2015 Thru 10-31-2018	11-01-2018 and beyond
10-01-2014	03-31-2015	04-01-2015 Thru 09-30-2015	10-01-2015 Thru 03-30-2016	3-31-2016 Thru 3-30-2019	3-31-2019 and beyond
10-01-2014	9-30-2015	N/A – Timely Filing Period has lapsed	10-01-2015 Thru 09-30-2016	10-1-2016 Thru 9-29-2019	09-30-2019 and beyond

Note that there is a special congressionally mandated time frame for adjustments/reopenings that are for higher weighted DRGs. These must be filed within 60 days from the initial claim determination.

Note that clerical errors or minor errors are limited to errors in form and content, and that omissions do not include failure to bill for certain items or services (for example, late charges).

Reopenings are also separate and distinct from the appeals process. A reopening will not be granted if an appeal has been requested, and a decision is pending or in process.

Decisions to allow reopenings are discretionary actions on the part of your A/MAC. An A/MAC’s decision to reopen a claim determination or refusal to reopen a claim determination is not an initial determination and is therefore not appealable. Requesting a reopening does not guarantee that request will be accepted and the claim determination will be revised, and does not extend the timeframe to request an appeal. If an A/MAC decides not to reopen an initial determination, the A/MAC will Return To Provider (RTP) the reopening request indicating that the A/MAC is not allowing this discretionary action. In this situation, the original initial determination stands as a binding decision, and appeal rights are retained on the original initial determination. New appeal rights are not triggered

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by the refusal to reopen, and the filing timeframes to request an appeal (which are based on the original initial determination on the RA) are not extended and do not “reset” following a contractor’s refusal to reopen. However, when an A/MAC reopens and revises an initial determination, that revised determination is a new determination with new appeal rights.

Providers are reminded that submission of adjustment bills (TOB xxx7) or reopening requests (TOB xxxQ) in response to claim denials resulting from review of medical records (including failure to submit medical records in response to a request for records) is not appropriate. Providers must submit appeal requests for such denials.

Additionally, many A/MACs allow reopenings to be submitted hardcopy (by mail or fax) or through a provider online portal. The creation of this new process does not eliminate or negate those processes. Contact your MAC about other ways reopenings may be submitted.

Also, due to ICD-10 implementation, currently scheduled for October 2015, the NUBC is going to delay implementation of the new bill type and condition codes until January 1, 2016. CMS will implement system changes in October, as scheduled, but will not allow the Front End Edits to accept these coding changes until January 2016. If there is a change in the ICD-10 implementation dates, we will re-issue this communication and provide the acceptance of the reopenings as scheduled with system changes in October 2015.

Finally, clarification was requested regarding the congressional exception to the adjustment and reopening process. As is currently the situation with adjustment and reopening processes, a provider cannot use the automation of the reopening process to reopen a claim to a higher weighted DRG after 60 days from the initial claim processing. The automation of the reopening process does not change this long standing congressional exception.

Definitions:

Timely Filing = 12 Calendar months from the date of service

(IOM 100-04, Chapter 1, Section 70.1 - Determining Start Date of Timely Filing Period -- Date of Service)

“For institutional claims (Form CMS-1450, the UB-04 and now the 837 I or its paper equivalent) that include span dates of service (that is, a “From” and “Through” date span on the claim), the “Through” date on the claim is used for determining the date of service for claims filing timeliness.”

Initial Claim Determinations = the date of the initial determination via an electronic or paper remittance advice (RA) (that is, A.K.A. the date on the 835) – see CFR 42 §405.921.

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Additional Information

The related CR 8581 may be viewed at <http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3060CP.pdf> on the CMS website.

To assist providers with claims coding a request for reopening, the following attachment was prepared with condition codes that may be used and scenarios using Adjustment Reason Codes, R1, R2 and R3.

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Attachment

Coding Requirements

(1) Type of Bill xxxQ

(2) An applicable Condition Code R1-R9

R1=Mathematical or computational mistake

R2=Inaccurate data entry

R3=Misapplication of a fee schedule

R4=Computer Errors

R5=Incorrectly Identified Duplicate

R6=Other Clerical Error or Minor Error or Omission (Failure to bill for services is not consider a considered a minor error

R7=Correction other than Clerical Error

R8=New and material evidence is available

R9=Faulty evidence (Initial determination was based on faulty evidence)

(3) A Condition Code to identify what was changed (if appropriate):

D0=Changes in service date

D1= Changes to charges

D2=Changes in Revenue Code/HCPCS/HIPPS Rate Codes

D4=Change in Clinical Codes (ICD) for Diagnosis and/or Procedure codes

D9=Change in Condition Codes, Occurrence Codes, Occurrence Span Codes, Provider ID, Modifiers and other changes

E0=Change in patient status

(4) A Condition Code W2=Duplicate of an original bill. When a provider uses this code they are attesting that they are reopening a bill already sent to the Medicare program and that there is no Appeal in Process. A provider cannot reopen a bill and appeal the same bill simultaneously.

(5) (For DDE claims only) An “Adjustment Reason Code” from the reopening subset below on claim page 3 (MAP1713)

R1 = < 1 yr Initial Determination (from Remittance Advice date)

R2 = 1 - 4 yr Initial Determination (from Remittance Advice date)

R3 = > 4 yr Initial Determination (from Remittance Advice date)

(6) Reopenings that require “Good Cause” to be documented must have a Remark/Note from the provider. Remarks/notes should be formatted as shown below **without the parenthetical**

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explanation (this is not an exhaustive list) and a narrative explanation after the word “because”. If the change or addition affects a line item (shown as bold) instead of a claim item, please indicate which lines are being changed in the remark/note. The first fifteen (15) characters of the remark/note must match exactly as shown below.

GOOD CAUSE- C-A CC (CHANGED OR ADDED CONDITION CODE) BECAUSE...

GOOD CAUSE- C-A OC (CHANGED OR ADDED OCCURRENCE CODE) BECAUSE...

GOOD CAUSE- C-A OSC (CHANGED OR ADDED OCCURRENCE SPAN CODE) BECAUSE...

GOOD CAUSE- C-A VC (CHANGED OR ADDED VALUE CODE) BECAUSE...

GOOD CAUSE- C-A DX (CHANGED OR ADDED DIAGNOSIS CODE) BECAUSE...

GOOD CAUSE- C-A **MOD** (CHANGED OR ADDED MODIFIER) BECAUSE...

GOOD CAUSE- C-A PX (CHANGED OR ADDED PROCEDURE CODE) BECAUSE...

GOOD CAUSE- C-A **LIDOS** (CHANGED OR ADDED LINE ITEM DATES OF SERVICE) BECAUSE...

GOOD CAUSE- C-A PSC (CHANGED OR ADDED PATIENT STATUS CODE) BECAUSE...

GOOD CAUSE- C-A **HCPCS**

GOOD CAUSE- C-A **HIPPS**

GOOD CAUSE- C-A OTHER BECAUSE...

GOOD CAUSE- NME (NEW AND MATERIAL EVIDENCE) BECAUSE...

GOOD CAUSE- F-E (FAULTY EVIDENCE) BECAUSE...

- (7) To assist in quickly processing a reopening, any reopening request that contains changes or additions from the original claim should contain a remark/note explaining what has been changed. If the change or addition affects a line item instead of a claim item, please indicate which lines are being changed in the remark/note.

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Reopening Request Scenarios (Examples are not all-inclusive)**Scenario A – Adjustment Reason Code R1**

Claim 1: Clerical Error – Minor Error – New Pricer/New Fee-Scheduled, Revised MCE, Revised IOCE, Revised NCD edits, Revised MUE edits

TOB	xxxQ	
Reopening Condition Code	R1	Mathematical or computational mistakes
Adjustment Condition Code	D9	Other
Duplicate Bill Condition Code	W2	Duplicate of an original bill
Adjustment Reason Code (For DDE Only)	R1	< 1 yr Initial Determination
Remarks – (Good Cause)	Not Required	May be added to provide additional information for claims processing.

Claim 2: Clerical Error – Minor Error – Keying Error

TOB	xxxQ	
Reopening Condition Code	R2	Inaccurate data entry (inverted code)
Adjustment Condition Code	D0 D1 D2 D4 D9 E0	Changes in service date Changes to charges Changes in Revenue Code/HCPCS/HIPPS Rate Codes Change in Clinical Codes (ICD) for Diagnosis and/or Procedure codes Change in Condition Codes, Occurrence Codes, Occurrence Span Codes, or Modifiers Change in patient status
Duplicate Bill Condition Code	W2	Duplicate of an original bill
Adjustment Reason Code (For DDE Only)	R1	< 1 yr Initial Determination
Remarks – (Good Cause)	Not Required	May be added to provide additional information for claims processing.

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Claim 3: Clerical Error – Minor Error – Wrong Locality or Wrong payment system used to Price the claim (Claim paid using the wrong locality or the locality wasn't loaded; or claim paid at CLFS and should have been paid cost or OPPS) Provider file not set up correctly.

TOB	xxxQ	
Reopening Condition Code	R3	Misapplication of a fee schedule
Adjustment Condition Code	D9	Other
Duplicate Bill Condition Code	W2	Duplicate of an original bill
Adjustment Reason Code (For DDE Only)	R1	< 1 yr Initial Determination
Remarks – (Good Cause)	Not Required	May be added to provide additional information for claims processing.

Claim 4: Clerical Error – Minor Error – (that is, Provider had wrong code or units hardcoded/loaded in their charge master or billing software)

TOB	xxxQ	
Reopening Condition Code	R4	Computer errors
Adjustment Condition Code	D1 D2 D4 D9 E0	Changes to charges Changes in Revenue Code/HCPCS/HIPPS Rate Codes Change in Clinical Codes (ICD) for Diagnosis and/or Procedure codes Change in Condition Codes, Occurrence Codes, Occurrence Span Codes, or Modifiers Change in patient status
Duplicate Bill Condition Code	W2	Duplicate of an original bill
Adjustment Reason Code (For DDE Only)	R1	< 1 yr Initial Determination
Remarks – (Good Cause)	Not Required	May be added to provide additional information for claims processing.

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Claim 5: Clerical Error – Minor Error – Incorrectly Identified Duplicate

TOB	xxxQ	
Reopening Condition Code	R5	Incorrectly Identified Duplicate
Adjustment Condition Code	D9	Other
Duplicate Bill Condition Code	W2	Duplicate of an original bill
Adjustment Reason Code (For DDE Only)	R1	< 1 yr Initial Determination
Remarks – (Good Cause)	Not Required	May be added to provide additional information for claims processing.

Claim 6a: Other Clerical Errors – Minor Errors – Coding Error (that is, incorrect data items such as discharge status, modifier or date of service.)

TOB	xxxQ	
Reopening Condition Code	R6	Incorrect data entry (used wrong code completely)
Adjustment Condition Code	D0 D1 D2 D4 D9 E0	Changes in service date Changes to charges Changes in Revenue Code/HCPCS/HIPPS Rate Codes Change in Clinical Codes (ICD) for Diagnosis and/or Procedure codes Change in Condition Codes, Occurrence Codes, Occurrence Span Codes, or Modifiers Change in patient status
Duplicate Bill Condition Code	W2	Duplicate of an original bill
Adjustment Reason Code (For DDE Only)	R1	< 1 yr Initial Determination
Remarks – (Good Cause)	Not Required	May be added to provide additional information for claims processing.

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Claim 6b: Other Clerical Errors – Omissions (that is, incorrect data items such as modifier or clinical information.)

TOB	xxxQ	
Reopening Condition Code	R6	Incorrect data entry (left off the code from billing)
Adjustment Condition Code	D2	Changes in Revenue Code/HCPSCS/HIPPS Rate Codes
	D4	Change in Clinical Codes (ICD) for Diagnosis and/or Procedure codes
	D9	Change in Condition Codes, Occurrence Codes, Occurrence Span Codes, or Modifiers
Duplicate Bill Condition Code	W2	Duplicate of an original bill
Adjustment Reason Code (For DDE Only)	R1	< 1 yr Initial Determination
Remarks – (Good Cause)	Not Required	May be added to provide additional information for claims processing.

Claim 7: Corrections Other than Clerical Errors – Computer System Omissions (that is, Off-site provider zip code, condition code, Occurrence Code, Occurrence Span Code, Value Code, Modifier)

TOB	xxxQ	
Reopening Condition Code	R7	Computer System Omission
Adjustment Condition Code	D2	Changes in Revenue Code/HCPSCS/HIPPS Rate Codes
	D4	Change in Clinical Codes (ICD) for Diagnosis and/or Procedure codes
	D9	Change in Condition Codes, Occurrence Codes, Occurrence Span Codes, Value Codes or Modifiers
Duplicate Bill Condition Code	W2	Duplicate of an original bill
Adjustment Reason Code (For DDE Only)	R1	< 1 yr Initial Determination
Remarks – (Good Cause)	Not Required	May be added to provide additional information for claims processing.

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Claim 8: Corrections Other than Clerical Errors – New and Material Evidence (subsequent test results, new documentation has become available since the initial determination)

TOB	xxxQ	
Reopening Condition Code	R8	New and Material Evidence
Adjustment Condition Code	D9	Other
Duplicate Bill Condition Code	W2	Duplicate of an original bill
Adjustment Reason Code (For DDE Only)	R1	< 1 yr Initial Determination
Remarks – (Good Cause)	Not Required	May be added to provide additional information for claims processing.

Claim 9: Corrections Other than Clerical Errors – Faulty Evidence

TOB	xxxQ	
Reopening Condition Code	R9	Faulty Evidence
Adjustment Condition Code	D9	Other
Duplicate Bill Condition Code	W2	Duplicate of an original bill
Adjustment Reason Code (For DDE Only)	R1	< 1 yr Initial Determination
Remarks – (Good Cause)	Not Required	May be added to provide additional information for claims processing.

Scenario B – Adjustment Reason Code R2

Claim 1: Clerical Error – Minor Error – New Pricer/New Fee-Scheduled, Revised MCE, Revised IOCE, Revised NCD edits, Revised MUE edits

TOB	xxxQ	
Reopening Condition Code	R1	Mathematical or computational mistakes
Adjustment Condition Code	D9	Other
Duplicate Bill Condition Code	W2	Duplicate of an original bill
Adjustment Reason Code (For DDE Only)	R2	1 -4 yrs from Initial Determination
Remarks – (Good Cause)	Yes	

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Claim 2: Clerical Error – Minor Error – Keying Error

TOB	xxxQ	
Reopening Condition Code	R2	Inaccurate data entry (inverted code)
Adjustment Condition Code	D0	Changes in service date
	D1	Changes to charges
	D2	Changes in Revenue Code/HCPCS/HIPPS Rate Codes
	D4	Change in Clinical Codes (ICD) for Diagnosis and/or Procedure codes
	D9	Change in Condition Codes, Occurrence Codes, Occurrence Span Codes, or Modifiers
	E0	Change in patient status
Duplicate Bill Condition Code	W2	Duplicate of an original bill
Adjustment Reason Code (For DDE Only)	R2	1 -4 yrs from Initial Determination
Remarks – (Good Cause)	Yes	

Claim 3: Clerical Error – Minor Error – Wrong Locality or Wrong payment system used to Price the claim (Claim paid using the wrong locality or the locality wasn't loaded; or claim paid at CLFS and should have been paid cost or OPPS) Provider file not set up correctly.

TOB	xxxQ	
Reopening Condition Code	R3	Misapplication of a fee schedule
Adjustment Condition Code	D9	Other
Duplicate Bill Condition Code	W2	Duplicate of an original bill
Adjustment Reason Code (For DDE Only)	R2	1 -4 yrs from Initial Determination
Remarks – (Good Cause)	Yes	

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Claim 4: Clerical Error – Minor Error – (that is, Provider had wrong code or units hardcoded/loaded in their charge master or billing software)

TOB	xxxQ	
Reopening Condition Code	R4	Computer errors
Adjustment Condition Code	D1	Changes to charges
	D2	Changes in Revenue Code/HCPCS/HIPPS Rate Codes
	D4	Change in Clinical Codes (ICD) for Diagnosis and/or Procedure codes
	D9	Change in Condition Codes, Occurrence Codes, Occurrence Span Codes, or Modifiers
	E0	Change in patient status
Duplicate Bill Condition Code	W2	Duplicate of an original bill
Adjustment Reason Code (For DDE Only)	R2	1 -4 yrs from Initial Determination
Remarks – (Good Cause)	Yes	

Claim 5: Clerical Error – Minor Error – Incorrectly Identified Duplicate

TOB	xxxQ	
Reopening Condition Code	R5	Incorrectly Identified Duplicate
Adjustment Condition Code	D9	Other
Duplicate Bill Condition Code	W2	Duplicate of an original bill
Adjustment Reason Code (For DDE Only)	R2	1 -4 yrs from Initial Determination
Remarks – (Good Cause)	Yes	

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Claim 6a: Other Clerical Errors – Minor Errors – Coding Error (that is, incorrect data items such as discharge status, modifier or date of service.)

TOB	xxxQ	
Reopening Condition Code	R6	Incorrect data entry (used wrong code completely)
Adjustment Condition Code	D0 D1 D2 D4 D9 E0	Changes in service date Changes to charges Changes in Revenue Code/HCPSC/HIPPS Rate Codes Change in Clinical Codes (ICD) for Diagnosis and/or Procedure codes Change in Condition Codes, Occurrence Codes, Occurrence Span Codes, or Modifiers Change in patient status
Duplicate Bill Condition Code	W2	Duplicate of an original bill
Adjustment Reason Code (For DDE Only)	R2	1 -4 yrs from Initial Determination
Remarks – (Good Cause)	Yes	

Claim 6b: Other Clerical Errors – Omissions (that is, incorrect data items such as modifier or clinical information.)

TOB	xxxQ	
Reopening Condition Code	R6	Incorrect data entry (left off the code from billing)
Adjustment Condition Code	D2 D4 D9	Changes in Revenue Code/HCPSC/HIPPS Rate Codes Change in Clinical Codes (ICD) for Diagnosis and/or Procedure codes Change in Condition Codes, Occurrence Codes, Occurrence Span Codes, or Modifiers
Duplicate Bill Condition Code	W2	Duplicate of an original bill
Adjustment Reason Code (For DDE Only)	R2	1 -4 yrs from Initial Determination
Remarks – (Good Cause)	Yes	

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Claim 7: Corrections Other than Clerical Errors – Computer System Omissions (that is, Off-site provider zip code, condition code, Occurrence Code, Occurrence Span Code, Value Code, Modifier)

TOB	xxxQ	
Reopening Condition Code	R7	Computer System Omission
Adjustment Condition Code	D2	Changes in Revenue Code/HCPCS/HIPPS Rate Codes
	D4	Change in Clinical Codes (ICD) for Diagnosis and/or Procedure codes
	D9	Change in Condition Codes, Occurrence Codes, Occurrence Span Codes, Value Codes or Modifiers
Duplicate Bill Condition Code	W2	Duplicate of an original bill
Adjustment Reason Code (For DDE Only)	R2	1 -4 yrs from Initial Determination
Remarks – (Good Cause)	Yes	

Claim 8: Corrections Other than Clerical Errors – New and Material Evidence (subsequent test results, new documentation has become available since the initial determination)

TOB	xxxQ	
Reopening Condition Code	R8	New and Material Evidence
Adjustment Condition Code	D9	Other
Duplicate Bill Condition Code	W2	Duplicate of an original bill
Adjustment Reason Code (For DDE Only)	R2	1 -4 yrs from Initial Determination
Remarks – (Good Cause)	Yes	

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Claim 9: Corrections Other than Clerical Errors – Faulty Evidence

TOB	xxxQ	
Reopening Condition Code	R9	Faulty Evidence
Adjustment Condition Code	D9	Other
Duplicate Bill Condition Code	W2	Duplicate of an original bill
Adjustment Reason Code	R2	1 -4 yrs from Initial Determination
Remarks – (Good Cause)	Yes	

Scenario C – Adjustment Reason Code R3

Claim 1: Corrections Other than Clerical Errors – New and Material Evidence (subsequent test results, new documentation has become available since the initial determination)

TOB	xxxQ	
Reopening Condition Code	R8	New and Material Evidence
Adjustment Condition Code	D9	Other
Duplicate Bill Condition Code	W2	Duplicate of an original bill
Adjustment Reason Code	R3	>4 yrs from Initial Determination
Remarks – (Good Cause)	Yes	

Claim 2: Corrections Other than Clerical Errors – Faulty Evidence

TOB	xxxQ	
Reopening Condition Code	R9	Faulty Evidence
Adjustment Condition Code	D9	Other
Duplicate Bill Condition Code	W2	Duplicate of an original bill
Adjustment Reason Code	R3	>4 yrs from Initial Determination
Remarks – (Good Cause)	Yes	

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Accepting Payment from Patients with a Medicare Set-Aside Arrangement

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Implementation Date: N/A

Note: We revised this article on February 19, 2020, to add information about submitting electronic attestations via the WCMSAP. This is in the Additional Information Section of the article. We added a note on page 2, regarding WCMSA funds. We also updated the link to an updated version of the WCMSA Reference Guide. All other information remains the same.

PROVIDER TYPE AFFECTED

This MLN Matters Article is for providers, physicians, and other suppliers who are told by patients that they must pay the bill themselves because they have a Medicare Set-Aside Arrangement (MSA).

WHAT YOU NEED TO KNOW

This article is based on information received from Medicare beneficiaries, their legal counsel, and other entities that assist these individuals, indicating that physicians, providers, and other suppliers are often reluctant to accept payment directly from Medicare beneficiaries who state they have a MSA and must pay for their services themselves. This article explains what an MSA is and explains why it is appropriate to accept payment from a patient that has a funded MSA.

Please review your billing practices to be sure they are in line with the information provided.

BACKGROUND

Medicare is always a secondary payer to liability insurance (including self-insurance), no-fault insurance, and workers' compensation benefits. The law precludes Medicare payment for services to the extent that payment has been made or can reasonably be expected to be made promptly. When future medical care is claimed, or a settlement, judgment, award, or other payment releases (or has the effect of releasing) claims for future medical care, it can reasonably be expected that the monies from the settlement, judgment, award, or other payment are available to pay for future medical items and services which are otherwise covered and reimbursable by Medicare.

Medicare should not be billed for future medical services until those funds are exhausted by payments to providers for services that would otherwise be covered and reimbursable by Medicare.

An MSA is a financial arrangement that allocates a portion of a settlement, judgment, award, or other payment to pay for future medical services. The law mandates protection of the Medicare trust funds but does not mandate an MSA as the vehicle used for that purpose. MSAs are the most frequently used formal method of preserving those funds for the Medicare beneficiary to pay for future items or services which are otherwise covered and reimbursable by Medicare and which are related to what was claimed or the settlement, judgment, award, or other payment had the effect of releasing. These funds must be exhausted before Medicare will pay for treatment related to the claimed injury, illness, or disease.

Medicare beneficiaries are advised that before receiving treatment for services to be paid by their MSA, they should advise their health care provider about the existence of the MSA. They are also notified that their health care providers should bill them directly, and that they should pay those charges out of the MSA **if**:

- The treatment or prescription is related to what was claimed or the settlement, judgment, award, or other payment had the effect of releasing AND
- The treatment or prescription is something Medicare would cover.

The obligation to protect the Medicare trust funds exists regardless of whether or not there is a formal CMS approved MSA amount. A Medicare beneficiary may or may not have documentation they can provide the physician, provider, or supplier from Medicare approving a Medicare Set-Aside amount.

PROVIDER ACTION NEEDED

Where a patient who is a Medicare beneficiary states that he/she is required to use funds from the settlement, judgment, award, or other payment to pay for the items or services related to what was claimed or which the settlement, judgment, award, or other payment, it is appropriate for you to document your records with that information and accept payment directly from the patient for such services.

Note: Providers should also accept payment from professional administrators holding Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) funds. Providers should not bill Medicare where a third party holds and administers one of these WCMSA funds.

ADDITIONAL INFORMATION

If you have questions, your MACs may have more information. Find their website at <http://go.cms.gov/MAC-website-list>

You can review a related document ([Workers' Compensation Medicare Set-Aside Arrangement \(WCMSA\) Reference Guide](#)) published in 2019. Beneficiaries may submit a WCMSA attestation electronically through the WCMSA Portal (WCMSAP), or send by mail, either as paper documents or CD. Using the WCMSAP for a WCMSA submission or attestation is the recommended approach as it is more efficient than mailing this information. For information about how to use the WCMSAP, please see the [WCMSAP](#) page.

DOCUMENT HISTORY

Date of Change	Description
February 19, 2020	We revised the article to add information about submitting electronic attestations via the WCMSAP. This is in the Additional Information Section of the article. We added a note on page 2, regarding WCMSA funds. We also updated the link to an updated version of the WCMSA Reference Guide.
July 2, 2019	We revised this article to add a link to the Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) Reference Guide
November 8, 2017	The article was revised to clarify information in the initial release. The title of the article was also changed to better reflect the information.
October 3, 2017	Rescinded
September 19, 2017	Initial article issued

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