


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



# Medicare Claim Submission Guidelines

FACT SHEET





This publication offers providers and suppliers the following information:

- ❖ Enrolling in the Medicare Program;
- ❖ Private contracts with Medicare beneficiaries;
- ❖ Filing Medicare claims;
- ❖ Deductibles, coinsurance, and copayments;
- ❖ Coordination of benefits (COB); and
- ❖ Resources.

## ENROLLING IN THE MEDICARE PROGRAM

To enroll in and obtain payment from Medicare, you must apply for:

- 1) A National Provider Identifier (NPI); and
- 2) Enrollment in the Medicare Program.

### 1) Applying for a National Provider Identifier (NPI)

The NPI is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard and a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses must use the NPI in the administrative and financial transactions adopted under HIPAA. Health care providers can apply for an NPI in one of three ways:

- ❖ Online – For the most efficient application processing and to get your NPI the fastest, you may apply using the web-based application process by logging

onto the National Plan and Provider Enumeration System (NPPES) at <https://nppes.cms.hhs.gov/NPPES/Welcome.do> on the NPPES website;

- ❖ Paper Application – You may obtain Form CMS-10114/National Provider Identifier (NPI) Application/Update Form and mail the completed and signed form to the NPI Enumerator. Staff at the NPI Enumerator will enter application data into the NPPES. You may access this form at <http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS10114.pdf> on the Centers for Medicare & Medicaid Services (CMS) website. You may also request the form from the NPI Enumerator by calling (800) 465-3203 or TTY (800) 692-2326, sending an e-mail to [customerservice@npienumerator.com](mailto:customerservice@npienumerator.com), or sending a letter to:  
NPI Enumerator  
P.O. Box 6059  
Fargo, ND 58108-6059; or
- ❖ Electronic File Interchange (EFI) – You may agree to have an EFI Organization (EFIO) submit application data on your behalf (i.e., through a bulk enumeration process) if an EFIO requests permission to do so.

For more information about the NPI, visit <http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/NationalProviderStand> on the CMS website. You may also refer to the Medicare Learning Network® (MLN) publication titled “The National Provider Identifier (NPI): What You

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Need to Know” located at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/NPIBooklet.pdf> and Chapter 10 of the “Medicare Program Integrity Manual” (Publication 100-08) located at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html> on the CMS website.

## 2) Applying for Enrollment in the Medicare Program

CMS collects information about you and secures documentation to ensure that you are qualified and eligible to enroll in the Medicare Program. You can apply for enrollment by using either:

- ❖ The Internet-based Provider Enrollment, Chain and Ownership System (PECOS); or
- ❖ The appropriate Form CMS-855 to complete the paper enrollment application process.

### *Internet-Based Provider Enrollment, Chain and Ownership System Enrollment (PECOS) Process*

You can use Internet-based PECOS to:

- ❖ Submit and electronically sign a Medicare enrollment application;
- ❖ Revalidate Medicare enrollment information;
- ❖ View or update existing enrollment information;
- ❖ Track the status of an enrollment application;
- ❖ Add or terminate a reassignment of benefits;
- ❖ Reactivate an existing enrollment record; and
- ❖ Voluntarily withdraw from the Medicare Program.

If you do not choose to electronically sign the enrollment application, after you submit the application, mail the signed and dated Certification Statement and any supporting documentation to your designated Medicare Contractor. To find Medicare Contractor contact information, refer to [http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/contact\\_list.pdf](http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/contact_list.pdf) on the CMS website.

### *Paper Enrollment Process*

Alternatively, you can apply for enrollment by completing and signing a paper enrollment application form, which is mailed along with any supporting documentation to your designated Medicare Contractor. Depending upon the provider or supplier type and the enrollment scenario, complete one of the following six CMS enrollment application forms to enroll in the Medicare Program:

- ❖ Form CMS-855A/Medicare Enrollment Application for Institutional Providers: Application used by institutional providers to apply for enrollment in the Medicare Program or make a change in their enrollment information;
- ❖ Form CMS-855B/Medicare Enrollment Application for Clinics/Group Practices and Certain Other Suppliers: Application used by group practices and other organizational suppliers, except durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers, to apply for enrollment in the Medicare Program or to make a change in their enrollment information;
- ❖ Form CMS-855I/Medicare Enrollment Application for Physicians and Non-Physician Practitioners: Application used by individual physicians or non-physician practitioners (NPP) to apply for enrollment in the Medicare Program or to make a change in their enrollment information;

- ❖ Form CMS-855O/Medicare Enrollment Application for Eligible Ordering and Referring Physicians and Non-Physician Practitioners: Application used by physicians and NPPs to apply for enrollment for the sole purpose of ordering and referring items and/or services for beneficiaries in the Medicare Program or to make a change in their enrollment information;
- ❖ Form CMS-855R/Medicare Enrollment Application for Reassignment of Medicare Benefits: Application used by individual physicians or NPPs to reassign Medicare payments or terminate a reassignment of Medicare benefits after enrollment in the Medicare Program or to make a change in their reassignment of Medicare benefit information; or
- ❖ Form CMS-855S/Medicare Enrollment Application for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Suppliers: Application used by suppliers of DMEPOS to apply for enrollment in the Medicare Program or to make a change in their enrollment information.

### ***Additional Required Form***

The following form is required in addition to the Medicare Enrollment Application:

- ❖ Form CMS-588/Electronic Funds Transfer (EFT) Authorization Agreement: Medicare authorization agreement to have payments sent directly to your financial institution through EFT.



### ***Additional Forms and Documentation That May Be Required***

The following forms may be required in addition to the Medicare Enrollment Application:

- ❖ Electronic Data Interchange (EDI) Enrollment Form and Centers for Medicare & Medicaid Services EDI Registration Form: Agreements executed when you submit electronic media claims (EMC) or use EDI, either directly with Medicare or through a billing service or clearinghouse. These forms must be completed prior to submitting EMC or other EDI transactions to Medicare; and
- ❖ Form CMS-460/Medicare Participating Physician or Supplier Agreement: Agreement you will submit if you wish to enroll as a Part B participating provider or supplier. The Participating and Nonparticipating Providers and Suppliers Section on pages 5 and 6 provides additional information about participating in the Medicare Program.

To access the forms discussed above, visit <http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-List.html> on the CMS website. The EDI enrollment and registration forms are also available from Medicare Contractors and Durable Medical Equipment Medicare Administrative Contractors (DME MAC). The Medicare Fee-For-Service Provider Enrollment Contact List provides information about where to send Medicare enrollment forms. The contact list is located at [http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/contact\\_list.pdf](http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/contact_list.pdf) on the CMS website.

Additional documentation, which may vary from State to State, may also be required to enroll in the Medicare Program. This documentation may include:

- ❖ A State medical license;
- ❖ An Occupational or Business license; and
- ❖ A Certificate of Use.



### ***Additional Requirements for Institutional Providers and Suppliers***

Institutional providers and suppliers must simultaneously contact their local State Survey Agency (SA), which determines Medicare participation requirements (certain provider types may elect voluntary accreditation by a CMS-recognized accrediting organization in lieu of a SA survey). For more information about institutional provider and supplier participation requirements, visit <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo> on the CMS website.

### ***Reporting Changes to Information in Enrollment Records***

You must report most changes to information in your Medicare enrollment records within 90 days of the reportable event.

The following reportable events must be reported within 30 days:

- ❖ A change in ownership;
- ❖ A change in practice location; and
- ❖ Final adverse actions that include:
  - Medicare-imposed revocation of any Medicare billing privileges;
  - Suspension or revocation of a license to provide health care by any State licensing authority;
  - Suspension or revocation by an accrediting organization;
  - Conviction of a Federal or State felony offense within the last 10 years preceding enrollment, revalidation, or re-enrollment; or
  - Exclusion or debarment from participation in a Federal or State health care program.

### ***Participating and Nonparticipating Providers and Suppliers***

There are two types of Part B providers and suppliers: participating and nonparticipating.

#### **1) Participating Providers and Suppliers:**

- ❖ Accept assignment of Medicare benefits for all covered services for all Medicare beneficiaries;
- ❖ Receive higher Physician Fee Schedule (PFS) allowances than nonparticipating providers and suppliers;
- ❖ Accept the Medicare allowed amount as payment in full (limiting charge provisions are not applicable); and
- ❖ Are included in the Medicare Participating Physicians and Suppliers Directory (MEDPARD).

When you complete and sign Form CMS-460/ Medicare Participating Physician or Supplier Agreement, you:

- ❖ Are formally notifying CMS that you wish to participate in the Medicare Program; and
- ❖ Agree to accept assignment on all Part B claims for all covered services for all Medicare beneficiaries.

Assignment means that you are paid the Medicare allowed amount as payment in full for all Part B claims for all covered services for all Medicare beneficiaries. You may not collect from the beneficiary any amount other than the unmet deductible and coinsurance. The following are always subject to assignment:

- ❖ Clinical diagnostic laboratory services and physician laboratory services;
- ❖ Physician services to individuals dually entitled to Medicare and Medicaid;

- ❖ Services furnished by the following providers:
  - Anesthesiologist assistants;
  - Certified nurse-midwives;
  - Certified registered nurse anesthetists;
  - Clinical nurse specialists;
  - Clinical psychologists;
  - Clinical social workers;
  - Medical nutrition therapists;
  - Nurse practitioners; and
  - Physician assistants;
- ❖ Ambulatory Surgical Center facility services;
- ❖ Services of mass immunization roster billers;
- ❖ Drugs and biologicals; and
- ❖ Ambulance services.

Participation is valid for a yearlong period from January 1 through December 31. Active participants get a postcard during the Medicare Participation Open Enrollment Period, which is usually in mid-November of each year. During this period, you can change your participation status, and that change will be effective on January 1 of the following year. If you wish to continue participating in the Medicare Program, you do not need to sign an



agreement each year. The Medicare Participating Physician or Supplier Agreement will remain in effect through December 31 of the calendar year and automatically renews each year unless you decide to terminate the agreement during the open enrollment period. Once you sign the Medicare Participating Physician or Supplier Agreement, CMS will rarely honor your decision to change participation status during the year.

## 2) Nonparticipating Providers and Suppliers:

- ❖ May accept assignment of Medicare claims on a claim-by-claim basis;
- ❖ Receive lower PFS allowances than participating providers and suppliers for assigned or nonassigned claims;
- ❖ May not submit charges for nonassigned claims that are in excess of the limiting charge amount (with the exception of pharmaceuticals, equipment, and supplies) and may collect up to the limiting charge amount at the time services are furnished, which is the maximum that can be charged for the services furnished (unless prohibited by an applicable State law); and
- ❖ Are not included in the MEDPARD.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
MEDICARE & MEDICAID SERVICES

OMB 0938-0047

**MEDICARE PARTICIPATING PHYSICIAN OR SUPPLIER AGREEMENT**

Address of Participant\*

National Provider Identifier (NPI)\*

Names and the NPI under which the participant files claims with the Medicare Administrative Contractor (MAC) from this agreement is being filed.

I, the named person or organization, called "the participant," hereby enters into an agreement with the Medicare Administrative Contractor (MAC) to accept assignment of the Medicare Part B payment for all services for which the participant is eligible for assignment under the Medicare law and regulations and which are furnished while this agreement is in effect.

**Meaning of Assignment:** For purposes of this agreement, accepting assignment of the Medicare Part B payment means requesting direct Part B payment from the Medicare program. Under an assignment, the Medicare Administrative Contractor (MAC) shall be the full charge for the service covered. The participant shall not collect from the beneficiary or other person or organization for covered services in excess of the applicable deductible and coinsurance.

2. **Effective Date:** If the participant files the agreement with any MAC/carrier during the enrollment period, the agreement becomes effective on the date the agreement is filed.

3. **Term and Termination of Agreement:** This agreement shall continue in effect through December 31 of the calendar year in which the agreement becomes effective and shall be renewed automatically for each 12-month period thereafter unless one of the following occurs:

a. The participant files a written notice of termination of this agreement with the MAC/carrier during the enrollment period provided near the end of any calendar year, the participant's agreement with the MAC/carrier terminates on the date the participant has filed the agreement or a

The table below provides an example of a limiting charge.

Amount	Example
<b>PFS Allowed Amount for Procedure “X”</b>	\$200.00
<b>Nonparticipating Provider or Supplier Allowed Amount for Procedure “X”</b>	\$190.00 ( $\$200.00 \times .95 = 5$ percent lower than PFS allowed amount)
<b>Limiting Charge for Procedure “X”</b>	\$218.50 ( $\$190.00 \times 1.15 = 115$ percent of PFS allowed amount)
<b>Beneficiary Coinsurance and Limiting Charge Portion Due to Provider or Supplier</b>	<p>\$ 66.50 (<math>\\$38.00</math> plus <math>\\$28.50</math>)            Coinsurance – 20 percent of PFS allowed amount (<math>\\$190.00 \times .20 = \\$38.00</math>)  <b>PLUS</b>  <math>\\$218.50</math> – Limiting charge  <math>- 190.00</math> – Nonparticipating provider/supplier allowed amount  <math>\\$ 28.50</math> – Additional amount that can be collected from the beneficiary</p>

Limiting charges apply to the following regardless of who furnishes or bills for them:

- ❖ Physicians’ services;
- ❖ Services and supplies commonly furnished in physicians’ offices that are incident to physicians’ services;
- ❖ Outpatient physical and occupational therapy services furnished by an independently practicing therapist;
- ❖ Diagnostic tests; and
- ❖ Radiation therapy services, including x-ray, radium, radioactive isotope therapy, materials, and technician services.





The table below illustrates the payment amounts that participating and nonparticipating providers and suppliers receive.

Amount	Participating Provider/Supplier	Nonparticipating Provider/Supplier Who Accepts Assignment	Nonparticipating Provider/Supplier Who Does Not Accept Assignment
<b>Submitted Amount</b>	\$125.00	\$125.00	\$109.25
<b>PFS Allowed Amount</b>	\$100.00	\$ 95.00	\$ 95.00
<b>80 Percent of PFS Allowed Amount</b>	\$ 80.00	\$ 76.00	\$ 76.00
<b>Beneficiary Coinsurance Due to Provider/Supplier (after deductible has been met)</b>	\$ 20.00	\$ 19.00	\$ 33.25
<b>Total Payment to Provider/Supplier (payment for nonassigned claims goes to the beneficiary, who is responsible for paying provider/supplier)</b>	\$100.00	\$ 95.00	\$109.25 (\$95.00 x 1.15 limiting charge)

For more information about enrolling in the Medicare Program, visit <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll> and refer to Chapters 1 and 24 of the “Medicare Claims Processing Manual” (Publication 100-04) and Chapters 10 and 15 of the “Medicare Program Integrity Manual” (Publication 100-08) located at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html> on the CMS website.

## PRIVATE CONTRACTS WITH MEDICARE BENEFICIARIES

The following physicians who are legally authorized to practice medicine, surgery, dentistry, podiatry, or optometry by the State in which such function or action is performed may opt-out of Medicare and privately contract with beneficiaries for the purpose of furnishing items or services that would otherwise be covered:

- ❖ Doctors of medicine or osteopathy;
- ❖ Doctors of dental surgery or dental medicine;
- ❖ Doctors of podiatry; and
- ❖ Doctors of optometry.



The following practitioners who are legally authorized to practice by the State and otherwise meet Medicare requirements may also opt-out of Medicare and privately contract with beneficiaries for the purpose of furnishing items or services that would otherwise be covered:

- ❖ Certified nurse-midwives;
- ❖ Certified registered nurse anesthetists;
- ❖ Clinical nurse specialists;
- ❖ Clinical psychologists;
- ❖ Clinical social workers;
- ❖ Nurse practitioners;
- ❖ Nutrition professionals;
- ❖ Physician assistants; and
- ❖ Registered dietitians.

The opt-out law does not define “physician” to include chiropractors; therefore, chiropractors may not opt-out of Medicare and provide services under private contract. Physical therapists and occupational therapists in independent practice cannot opt-out because they are not within the opt-out law’s definition of either a “physician” or “practitioner.”

The opt-out period is for two years and can only be terminated early (no later than 90 days after the effective date of the opt-out affidavit) by a physician or practitioner who has not previously opted out. Opt-outs may be renewed for subsequent two-year periods. You must opt-out of Medicare for all beneficiaries and all items or services, with the exception of emergency or urgent care situations, in which case you may treat a beneficiary with whom you do not have a private contract and bill Medicare for the treatment. Claims for emergency or urgent care require modifier GJ, “Opt-out physician or practitioner emergency or urgent service.”

If you have opted out of Medicare, payment will be made for covered medically necessary items or services that you order if:

- ❖ You have acquired a provider identifier; and
- ❖ The items or services are not furnished by a physician or practitioner who has also opted-out of Medicare.

For more information about private contracts with Medicare beneficiaries, refer to Chapter 15 of the “Medicare Benefit Policy Manual” (Publication 100-02) located at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html> on the CMS website.

## FILING MEDICARE CLAIMS

A claim is defined as a request for payment for benefits or services received by a beneficiary. When you furnish covered services to Medicare beneficiaries, you are required to submit claims for your services and cannot charge beneficiaries for completing or filing a Medicare claim. Medicare Contractors monitor compliance with these requirements. Offenders may be subject to a Civil Monetary Penalty of up to \$10,000 for each violation.

### *Exceptions to Mandatory Filing*

You are not required to file claims on behalf of Medicare beneficiaries when:

- ❖ The claim is for services for which:
  - Medicare is the secondary payer;
  - The primary insurer’s payment is made directly to the beneficiary; and
  - The beneficiary has not furnished the primary payment information needed to submit the Medicare secondary claim;
- ❖ The claim is for services furnished outside the U.S.;

- ❖ The claim is for services initially paid by third-party insurers who then file Medicare claims to recoup what Medicare pays as the primary insurer (e.g., indirect payment provisions);
- ❖ The claim is for other unusual services, which are evaluated by Medicare Contractors on a case-by-case basis;
- ❖ The claim is for excluded services, unless the beneficiary requests submission of a claim to Medicare (some supplemental insurers who pay for these services may require a Medicare claim denial notice prior to making payment);
- ❖ The beneficiary signed Form CMS-R-131/Advance Beneficiary Notice of Noncoverage (ABN), indicating that no claim should be filed for a specific item or service;
- ❖ You opted-out of the Medicare Program and entered into a private contract with the beneficiary (when you opt-out of Medicare and privately contract with beneficiaries for the purpose of furnishing items or services that would otherwise be covered, you cannot submit claims for these services); or
- ❖ You have been excluded or debarred from the Medicare Program (when you have been excluded or debarred from the Medicare Program, you cannot submit claims for your services).

### ***Timely Filing Requirement***

Before payment can be made for Medicare-covered services, claims must be filed timely. Claims must be received no later than one calendar year from the claim's date of service. Claims filed after the specified timeframe will be denied with no appeal rights. For claims that include span dates of service, claims filing timeliness is determined as follows:

- ❖ The "Through" date is used to determine the date of service for institutional claims; and

- ❖ The "From" date is used to determine the date of service for professional claims.

Exceptions to the timely filing requirement include the following:

- ❖ Administrative error, if failure to meet the filing deadline was caused by error or misrepresentation of an employee, Medicare Contractor, or agent of the U.S. Department of Health and Human Services that was performing Medicare functions and acting within the scope of its authority;
- ❖ Retroactive Medicare entitlement;
- ❖ Retroactive Medicare entitlement involving State Medicaid Agencies and dually-eligible beneficiaries; and
- ❖ Retroactive disenrollment from a Medicare Advantage Plan or Program of All-Inclusive Care for the Elderly provider organization.

### ***Electronic Claims***

You must submit claims electronically via EDI in the HIPAA format, except in limited situations.

You must complete the Electronic Data Interchange (EDI) Enrollment Form and send it to your designated Medicare Contractor prior to submitting EMC. A sender number, which is required to submit electronic claims, will then be issued. An organization comprised of multiple components that have been assigned more than one Medicare provider identifier may elect to execute a single EDI Enrollment Form on behalf of the organizational components to which these identifiers have been assigned.

### ***Electronic Media Claim (EMC) Submissions***

Claims are electronically transmitted to the Medicare Contractor's system, which verifies claim data. This information is then electronically checked or edited for required information. Claims that pass

## HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE <input type="checkbox"/> (Medicare #)		MEDICAID <input type="checkbox"/> (Medicaid #)	TRICARE CHAMPUS (Sponsor's SSN) <input type="checkbox"/>	CHAMPVA <input type="checkbox"/> (Member ID#)	GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/>	FCA BLK LUNG (SSN) <input type="checkbox"/>	OTHER (ID) <input type="checkbox"/>	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY			SEX M <input type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. INSURED'S ADDRESS (No., Street)							7. INSURED'S ADDRESS (No., Street)	

these initial edits, also called front-end or pre-edits, are processed in the claims processing system according to Medicare policies and guidelines. Claims with inadequate or incorrect information may:

- ❖ Be returned to you for correction;
- ❖ Be suspended in the Medicare Contractor's system for correction; or
- ❖ Be corrected by the system (in some cases).

A confirmation or acknowledgment report, which indicates the number of claims accepted and the total dollar amount transmitted, is generated to you. This report also indicates the claims that have been rejected and reason(s) for the rejection.

### **Electronic Media Claim (EMC) Submission Alternatives**

If you do not submit electronic claims using EMC, you may alternatively choose to submit claims through an electronic billing software vendor or clearinghouse, billing agent, or by using Medicare's free billing software. You can obtain a list of electronic billing software vendors and clearinghouses as well as billing software from your Medicare Contractor.

### **Paper Claims**

In limited situations, you may submit paper claims to Medicare. To find more information about when you may submit paper claims, visit <http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/ASCASelfAssessment.html> on the CMS website.

Non-institutional providers and suppliers use Form CMS-1500 to bill Medicare Contractors and DME MACs. You can order Form CMS-1500 from printing companies, office

supply stores, and the U.S. Government Printing Office (GPO), U.S. Government Bookstore. U.S. Government Bookstore orders can be placed by calling (866) 512-1800 or visiting <http://bookstore.gpo.gov/collections/cms1500-form.jsp> on the GPO website.

Institutional providers and suppliers use Form CMS-1450, also known as the UB-04, to bill Medicare Contractors. You can order UB-04 claim forms from the National Uniform Billing Committee (NUBC) at <http://www.nubc.org/guide.html> on the NUBC website.

### **Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) and Parenteral and Enteral Nutrition (PEN) Claims**

DME MACs have jurisdiction for the following claims:

- ❖ Nonimplantable DMEPOS (including items for home use);
- ❖ Parenteral and enteral nutrition (PEN) products (other than items furnished to inpatients covered under Part A);
- ❖ Certain oral drugs billed by pharmacies; and
- ❖ Medications delivered through infusion pumps.

For more information about filing Medicare claims, refer to Chapter 1 of the "Medicare Claims Processing Manual" (Publication 100-04) at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html> on the CMS website.

For more information about DMEPOS and PEN claims, visit <http://www.cms.gov/Center/Provider-Type/Durable-Medical-Equipment-DME-Center.html> on the CMS website.

## DEDUCTIBLES, COINSURANCE, AND COPAYMENTS

You must collect unmet deductibles, coinsurance, and copayments from the beneficiary. The deductible is the amount a beneficiary must pay before Medicare begins to pay for covered services and supplies. These amounts can change every year. Under Fee-For-Service Medicare and Medicare Advantage Private Fee-For-Service Plans, coinsurance is a percentage of covered charges that the beneficiary may pay after he or she has met the applicable deductible. You should determine whether the beneficiary has supplemental insurance that will pay for deductibles and coinsurance before billing him or her for them. In some Medicare health plans, a copayment is the amount that the beneficiary pays for each medical service. If a beneficiary is unable to pay these charges, he or she should sign a waiver that explains the financial hardship. If a waiver is not assigned, the beneficiary's medical record should reflect normal and reasonable attempts to collect the charges before they are written off. The same attempts to collect charges must be applied to both Medicare beneficiaries and non-Medicare beneficiaries. Consistently waiving deductibles, coinsurance, and copayments may be interpreted as program abuse.

On assigned claims, the beneficiary is responsible for:

- ❖ Unmet deductibles;
- ❖ Applicable coinsurance and copayments; and
- ❖ Charges for services and supplies that are not covered under the Medicare Program.

For more information about deductibles, coinsurance, and copayments, refer to Chapter 3 of the “Medicare General Information, Eligibility and Entitlement Manual” (Publication 100-01) and Chapter 1

of the “Medicare Claims Processing Manual” (Publication 100-04) located at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html> on the CMS website.

## COORDINATION OF BENEFITS (COB)

COB is the process that determines the respective responsibilities of two or more payers that have some financial responsibility for a medical claim.

### *Medicare Secondary Payer (MSP) Program*

Under Medicare law, prior to submitting a claim, you must determine whether Medicare is the primary or secondary payer by asking the beneficiary or his or her representative about other health insurance or coverage. In addition, you must identify primary payers on claims submitted to Medicare. You should not rely on Common Working File (CWF) information alone since Medicare Secondary Payer (MSP) circumstances can change quickly. The following secondary payer information can be found via the MSP Auxiliary File in the CWF:

- ❖ MSP effective date;
- ❖ MSP termination date;
- ❖ Patient relationship;
- ❖ Subscriber name;
- ❖ Subscriber policy number;
- ❖ Insurer type;
- ❖ Insurer information (name, group number, address, city, State, and ZIP code);
- ❖ MSP type;
- ❖ Remarks code;
- ❖ Employer information (name, address, city, State, and ZIP code); and
- ❖ Employee information (identification number).

Medicare may make payment if the primary payer denies the claim and you include documentation that the claim has been denied in the following situations:

- ❖ The Group Health Plan (GHP) denies payment for services because:
  - The beneficiary is not covered by the health plan;
  - Benefits under the plan are exhausted for particular services;
  - The services are not covered under the plan;
  - A deductible applies; or
  - The beneficiary is not entitled to benefits;
- ❖ The no-fault or liability insurer denies payment or does not pay the bill because benefits have been exhausted;
- ❖ The Workers' Compensation (WC) Plan denies payment (e.g., when it is not required to pay for certain medical conditions); or
- ❖ The Federal Black Lung Program does not pay the bill.

In liability, no-fault, or WC situations, Medicare may make a conditional payment for covered services to prevent beneficiary financial hardship when:

- ❖ The claim is not expected to be paid promptly;
- ❖ The properly submitted claim was denied in whole or in part; or
- ❖ A proper claim has not been filed with the primary insurer due to the beneficiary's physical or mental incapacity.

When payments are made under these situations, they are made on the condition that the insurer and/or the beneficiary will reimburse Medicare to the extent that payment is subsequently made by the insurer.

## **Coordination of Benefits (COB) Contractor**

The COB Contractor performs activities that support the collection, management, and reporting of other health insurance or coverage for Medicare beneficiaries. It identifies the health benefits available to Medicare beneficiaries and coordinates the payment process to prevent mistaken payment of Medicare benefits. The COB Contractor can assist you with:

- ❖ Reporting employment changes and other insurance coverage information;
- ❖ Reporting a liability, auto/no-fault, or WC case;
- ❖ MSP issues; and
- ❖ Medicare Secondary Development letters and questionnaires.

The COB Contractor determines whether beneficiaries have health insurance that is primary to Medicare through the following mechanisms:

- ❖ The Initial Enrollment Questionnaire, which asks about other health insurance or coverage, is sent to beneficiaries approximately three months before Medicare coverage begins;
- ❖ U.S. Internal Revenue Service, U.S. Social Security Administration, and CMS data match, which are completed by employers about GHP coverage for identified workers who are either entitled to Medicare or married to a Medicare beneficiary;
- ❖ MSP claims investigation, which involves the collection of data about health insurance or coverage that may be primary to Medicare based on information submitted on a medical claim or from other sources; and
- ❖ Voluntary MSP data match agreements, which are an electronic data exchange of GHP eligibility and Medicare information between CMS and employers or insurers.



The COB Contractor does not process claims for primary or secondary payment or handle any mistaken payment recoveries, claims-specific inquiries, claim or service denials and adjustments, or billing issues. Medicare Contractors complete these responsibilities.

COB Contractor contact information is listed below.

Telephone: (800) 999-1118

General written inquiries:

MEDICARE - COB  
P.O. Box 33847  
Detroit, MI 48232

Questionnaires and correspondence:

MEDICARE - COB  
Data Match Project  
P.O. Box 33848  
Detroit, MI 48232

MEDICARE - COB  
Initial Enrollment Questionnaire Project  
P.O. Box 17521  
Baltimore, MD 21203-7521

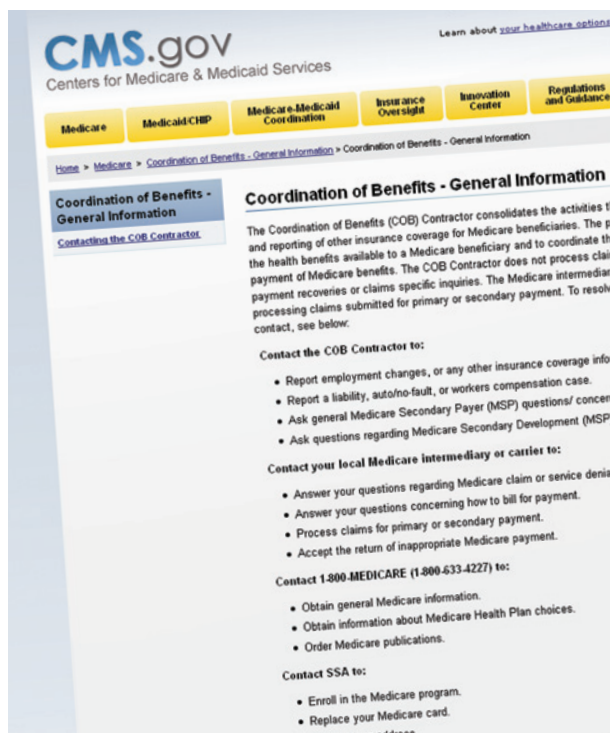
MEDICARE - COB  
MSP Claims Investigation Project  
P.O. Box 33847  
Detroit, MI 48232

MEDICARE - COB  
Voluntary Agreement Project  
P.O. Box 660  
New York, NY 10274-0660

MEDICARE - COB  
Employer/Insurer Outreach  
P.O. Box 660  
New York, NY 10274

MEDICARE - COB  
Small Employer Exemptions  
P.O. Box 660  
New York, NY 10274

CMS c/o COB Contractor  
Workers' Compensation Medicare  
Set-Aside Arrangements Proposal/  
Final Settlement  
P.O. Box 33849  
Detroit, MI 48232



For more information about COB, visit <http://www.cms.gov/Medicare/Coordination-of-Benefits/COBGeneralInformation> on the CMS website. You may also refer to the “Medicare General Information, Eligibility, and Entitlement Manual” (Publication 100-01) and the “Medicare Secondary Payer Manual” (Publication 100-05) located at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html> on the CMS website.



## RESOURCES

For more information about submitting Medicare claims, refer to the MLN publication titled “MLN Guided Pathways to Medicare Resources Basic Curriculum for Health Care



Providers” located at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/Guided\\_Pathways\\_Basic\\_Booklet.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/Guided_Pathways_Basic_Booklet.pdf) on the CMS website. For information about all available MLN products (e.g., brochures, training guides, and more), refer to the “Medicare Learning Network® Catalog of Products” located at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNCatalog.pdf> on the CMS website or scan the Quick Response (QR) code on the right. To find Medicare information for beneficiaries (e.g., Medicare basics, managing health, and resources), visit <http://www.medicare.gov> on the CMS website.



This fact sheet was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

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