Program Memorandum Carriers

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal B-03-003 **Date: JANUARY 24, 2003**

CHANGE REQUEST 2416

THIS PROGRAM MEMORANDUM (PM) IMPLEMENTS PARAGRAPH 3 OF THE ACTIONS SECTION OF PROGRAM MEMORANDUM AB-02-168, CHANGE REQUEST 2415 DATED NOVEMBER 22, 2002.

SUBJECT: Section II.8, Processing Initial Denials, of the DMEPOS Refund Requirements - Implementation of Limits on Beneficiary Liability for Medical Equipment and Supplies - Change

This PM establishes the implementation date for Section II.8, Processing Initial Denials, of PM AB-02-168 Part II - Instructions for Carriers and Suppliers on Limits on Beneficiary Liability for Medical Equipment and Supplies.

Actions

This PM requires DMERCs to: 1) Implement Section II.8 of PM AB-02-168 Part II - Instructions for Carriers and Suppliers on Limits on Beneficiary Liability for Medical Equipment and Supplies (and reissued without revision in this PM) no later than July 1, 2003, and 2) Publish a notice to DMEPOS suppliers on their Web sites no later than June 1, 2003, announcing that these instructions, Section II.8, will be effective as of July 1, 2003. DMERCs may implement Section II.8 on a voluntary basis prior to July 1, 2003 and, in that case, should make the required announcement on their Web site prior to actual implementation. Policy Changes associated with CR 2416 were implemented by PM AB-02-168 (CR 2415) and went into effect January 1, 2003.

Section II.8 Processing Initial Denials

In any unassigned claim for medical equipment and supplies furnished on or after January 1, 1995, in which you deny payment on the basis of §1862(a)(1), §1834(a)(17)(B), §1834(j)(1), or §1834(a)(15) of the Social Security Act (the Act), send separate notices to both the beneficiary (a Medicare Summary Notice (MSN)) and the supplier (a remittance advice (RA)).

NOTE: This instruction to send a remittance advice to the supplier in the case of denial of an unassigned claim is a specific requirement of §1834(a)(18)(C) of the Act, incorporated by reference into §1834(j)(4) and §1879(h) of the Act, applicable to denials of claims for medical equipment and supplies furnished on or after January 1, 1995.

If the beneficiary signed an Advance Beneficiary Notice (ABN) which satisfies the requirements in subsection II.6 and the supplier included a GA modifier on the Form CMS-1500 to that effect, do not make an automatic finding that the claim should be denied on the basis of §1862(a)(1), §1834(a)(17)(B), §1834(j)(1), or §1834(a)(15) of the Act, merely because the supplier submitted a GA modifier. The fact that an ABN was given to the beneficiary must in no way prejudice your determination as to whether there is or is not sufficient evidence to justify a denial. In the case where there is an ABN, mail a standard denial MSN notice to the beneficiary. If the beneficiary did not sign an ABN and the supplier included a GZ modifier on the Form CMS-1500 to that effect, include, in addition to one of the denial notices in §7012.15.0.ff., the following initial beneficiary notice in the MSN sent to the beneficiary.

A. Initial Beneficiary Notice--(MSN 8.54) "If the supplier should have known that Medicare would not pay for the denied items or services and did not tell you in writing before providing them that Medicare probably would deny payment, you may be entitled to a refund of any amounts you paid. However, if the supplier requests a review of this claim within 30 days, a refund is not required until we complete our review. If you paid for this service and do not hear anything about a refund within the next 30 days, contact your supplier."

(MSN 8.54) "Si el suplidor hubiera sabido que Medicare no pagaría por los artículos o servicios negados y no le informó por escrito, antes de proveerle los artículos o servicios, que Medicare probablemente negaría el pago, usted podría tener derecho a recibir un reembolso por cualquier cantidad que pagó. Sin embargo, si el suplidor pide una revisión de esta reclamación en 30 días, un reembolso no es requerido hasta que completemos nuestra revisión. Si usted pagó por este servicio y no escucha nada sobre un reembolso en 30 días, comuníquese con su suplidor."

B. Initial Supplier Notice--Include in the notice to the supplier the following:

- The patient's name and health insurance claim number;
- A description of the item or service by procedure code, date and place of service, and amount of the charge;
- The same denial notice included on the beneficiary's MSN, (see §7012.15.0.ff. of the Medicare Carriers Manual (MCM)); and
- If the supplier submitted a GA modifier (signed ABN obtained), include in the notice to the supplier the following Notice 1. However, if the supplier submitted a GZ modifier (a signed ABN was not obtained), include in the notice to the supplier the following Notice 2.

Notice 1. – Signed Advance Beneficiary Notice Obtained

(Remark Code N124) "Payment has been (denied for the/made only for a less extensive) service/item because the information furnished does not substantiate the need for the (more extensive) service/item. The patient is liable for the charges for this service/item as you informed the patient in writing before the service/item was furnished that we would not pay for it, and the patient agreed to pay."

or

Notice 2. – Signed Advance Beneficiary Notice Not Obtained

(Remark Code N125) "Payment has been (denied for the/made only for a less extensive) service/item because the information furnished does not substantiate the need for the (more extensive) service/item. If you have collected any amount from the patient, you must refund that amount to the patient within 30 days of receiving this notice. The law permits exceptions to this refund requirement in two cases: If you did not know, and could not have reasonably been expected to know, that Medicare would not pay for this service/item; or if you notified the beneficiary in writing before providing it that Medicare likely would deny the service/item, and the beneficiary signed a statement agreeing to pay.

If an exception applies to you, or you believe the carrier was wrong in denying payment, you should request review of this determination by the carrier within 30 days of receiving this notice. Your request for review should include any additional information necessary to support your position. If you request review within 30-days, you may delay refunding to the beneficiary until you receive the results of the review. If the review determination is favorable to you, you do not have to make any refund. If the review is unfavorable, you must make the refund within 15 days of receiving the unfavorable review decision.

You may request review of the determination at any time within 120 days of receiving this notice. A review requested after the 30-day period does not permit you to delay making the refund. Regardless of when a review is requested, the patient will be notified that you have requested one, and will receive a copy of the determination.

The patient has received a separate notice of this denial decision. The notice advises that he or she may be entitled to a refund of any amounts paid, if you should have known that Medicare would not pay and did not tell him or her. It also instructs the patient to contact your office if he or she does not hear anything about a refund within 30 days.

The requirements for refund are in §1834(a)(18) of the Act (and in §§1834(j)(4) and 1879(h) by cross-reference to §1834(a)(18)). Section 1834(a)(18)(B) of the Act specifies that suppliers which knowingly and willfully fail to make appropriate refunds may be subject to civil money penalties and/or exclusion from the Medicare program. If you have any questions about this notice, please contact (carrier contact, telephone number)."

Ensure that the telephone number puts the supplier in touch with a knowledgeable professional who can discuss the basis for the denial or reduction in payment.

NOTE: These procedures do not apply to claims you automatically deny under the A/B link procedures in §4169 of the MCM. In those cases, the Quality Improvement Organization is responsible for notifying the beneficiary and supplier of the refund requirements of §§1834(a)(18), 1834(j)(4) and 1879(h) of the Act and making the refund determination where appropriate.

The *effective date for Systems Changes* for this PM is July 1, 2003.

The *implementation date for Systems Changes* for this PM is July 1, 2003.

This PM may be discarded July 1, 2004.

These instructions should be implemented within your current operating budget.

Questions related to this request should be addressed to Raymond Boyd, RBoyd@cms.hhs.gov, 410-786-4544.