CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 955

Department of Health & Human Services (DHHS)

Centers for Medicare & Medicaid Services (CMS)

Date: MAY 19, 2006

Change Request 5062

NOTE: Transmittal 945, Change Request 5062, dated May 12, 2006 is rescinded and replaced with Transmittal 955, dated May 19, 2006. The responsibility column for Business Requirements 5062.2.1 and 5062.4 were inadvertently not marked and section 10.3.1 in the manual was modified. All other material remains the same.

SUBJECT: Quarterly Medicare Summary Notice (MSN) Printing Cycle

I. SUMMARY OF CHANGES: This Change Request instructs contractors to print and mail No-pay MSNs on a quarterly basis.

NEW/REVISED MATERIAL

EFFECTIVE DATE: MCS-June 12, 2006, VMS-July 1, 2006, FISS-September 1, 2006

IMPLEMENTATION DATE: MCS-June 12, 2006, VMS-July 3, 2006, FISS-September 1, 2006

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

II. CHANGES IN MANUAL INSTRUCTIONS:

R = REVISED, N = NEW, D = DELETED

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	21/10/General Medicare Summary Notices (MSN) Requirements
R	21/10.1/General Requirements for the MSN
R	21/10.3.1/General Requirements - MSN
R	21/10.3.6/Claims Information Section
R	21/50.38/General Information Section
R	21/90.38/Sección De Información General

III. FUNDING:

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 955	Date: May 19, 2006	Change Request 5062

NOTE: Transmittal 945, Change Request 5062, dated May 12, 2006 is rescinded and replaced with Transmittal 955, dated May 19, 2006. The responsibility column for Business Requirements 5062.2.1 and 5062.4 were inadvertently not marked and section 10.3.1 in the manual was modified. All other material remains the same.

SUBJECT: Quarterly Medicare Summary Notice (MSN) Printing Cycle

I. GENERAL INFORMATION

A. Background: The current MSN instructions require all Medicare contractors to issue an MSN to each beneficiary for whom a claim was processed during the last 30 days to inform the beneficiary of the disposition of all claims.

NOTE: The beneficiary could have received the service longer than 30 days ago.

B. Policy: In an effort to reduce overall contractor operating costs, contractors will change their current No- Pay MSN mailing schedule from a monthly to a quarterly basis. No-Pay MSNs are the standard system generated MSNs produced for beneficiaries in which Medicare did not issue payment to the beneficiary for the respective claim. All MSN information should continue to print, but summations will occur on a quarterly basis as opposed to a 30 day basis. Beneficiaries shall be able to request a No-Pay MSN by calling 1-800 Medicare, in those situations where a No-Pay MSN is needed or lost. On demand requests will be generated and mailed once the request occurs.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5062.1	Upon implementation, contractors shall issue No-Pay MSNs on a quarterly/90 day mailing cycle. To the extent possible, contractors shall stagger the mailing of the quarterly MSN over the entire quarter.	X	X	X	X	X	X	X		

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5062.2	Contractors shall educate beneficiaries about this mailing change by posting an informational alert on their beneficiary Web site and through regular educational efforts with partners, advocacy groups etc.	X	X	X	X	X	X	X		
5062.2.1	In addition, contractors shall print the following General Information section message on all MSNs beginning 30 days from issuance or as soon as possible. All contractors must continue to print this message until May 31, 2007. English: If you are not due a payment check from Medicare, your Medicare Summary Notices (MSN) will now be mailed to you on a quarterly basis. You will no longer receive a monthly statement in the mail for these types of MSNs. You will now receive a statement every 90 days summarizing all of your Medicare claims. You may receive a bill from your provider before you receive an MSN. Please compare the MSN with the bill from your provider to ensure you paid the appropriate amount for your services. Spanish: Si Medicare no le debe un pago por cheque, sus Resúmenes de Medicare (MSN, por sus siglas en inglés) serán enviados por correo cada tres meses. Usted no recibirá un resumen mensual en su correo si Medicare no le debe un pago por cheque. De ahora en adelante, usted recibirá un aviso como éste (que no incluye pago por cheque) cada 90 días resumiendo todas sus reclamaciones de Medicare. Usted puede recibir una factura de su proveedor antes de que reciba un aviso de MSN. Por favor compare el MSN con la factura que le envió su proveedor para asegurarse de que pagó la	X	X	X	X					

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	cantidad correcta por sus servicios.									
5062.3	Contractors shall provide their projected level of costs and savings from decreasing the frequency of No-Pay MSNs from monthly to quarterly in FY 2007 to Douglas Nock Douglas.nock@cms.hhs.gov no later than 2 weeks from issuance.	X	X	X	X	X	X	X		

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5062.4	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in	X	X	X	X					

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	billing and administering the Medicare program correctly.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: MCS-June 12, 2006, VMS-July 1, 2006, FISS-September 1, 2006 **Implementation Date:** MCS-June 12, 2006, VMS-July 3, 2006, FISS-September 1, 2006 **Pre-Implementation Contact(s):** Julie Day at 410-786-6343 Julie.day@cms.hhs.gov or Nancy Conn at 410-786-8374 nancy.conn@cms.hhs.gov. Direct all inquiries related to business requirement 5062.3 to	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.**

Doug Nock at Douglas.Nock@cms.hhs.gov. **Post-Implementation Contact(s):** Julie Day at 410-786-6343 Julie.day@cms.hhs.gov or Nancy Conn at 410-786-8374 nancy.conn@cms.hhs.gov.	

*__Unless otherwise specified, the effective date is the date of service.__

10 - General Medicare Summary Notices (MSN) Requirements

(Rev. 955, Issued: 05-19-06, Effective: MCS-June 12, 2006, VMS-July 1, 2006, FISS-September 1, 2006; Implementation: MCS-June 12, 2006, VMS-July 3, 2006, FISS-September 1, 2006)

Effective July 1, 2002, the MSN is used by all carriers and intermediaries.

The MSN is the primary vehicle by which beneficiaries are notified of decisions on their claims for Medicare benefits. The intermediary or carrier mails a single MSN at the end of the month to each beneficiary for whom claim was processed during the month to inform the beneficiary of the disposition of all claims. *Contractors shall issue No-Pay MSNs on a quarterly/90 day mailing cycle. MSNs with checks to the beneficiary will continue to be mailed out as processed.* To ensure that all messages are uniform throughout the Medicare program, intermediaries and carriers may not use locally developed MSN messages until approved by the regional office (RO).

The MSNs are not sent to providers. Providers receive remittance advice records. (See Chapter 22 for instructions about the provider remittance record.)

The MSN contains the following sections or areas:

- Disclaimer;
- Title;
- Claims Information;
- Message; and
- Appeals.

Detailed requirements for completion of each section are included in §10.3. Generally, carrier and intermediary requirements are the same. Where there are differences or where the specific specification applies to only the carrier or to only the intermediary, the difference is noted in the specific instruction.

Although every attempt has been made to make the MSN as simple as possible, the MSN is sufficiently complex that contractors must maintain continuing training efforts directed at beneficiaries and providers for understanding and interpretation of data on the MSN. Although providers are not mailed copies of MSNs, beneficiaries frequently show MSNs to providers to establish deductible status for provider billing.

10.1 - General Requirements for the MSN

(Rev. 955, Issued: 05-19-06, Effective: MCS-June 12, 2006, VMS-July 1, 2006, FISS-September 1, 2006; Implementation: MCS-June 12, 2006, VMS-July 3, 2006, FISS-September 1, 2006)

A. Intermediary/RHHI MSN

The MSN is used to notify Medicare beneficiaries of action taken on intermediary processed claims. MSNs are not used by RHHIs for RAPs, and RAP data are not included on the monthly MSN.

The MSN provides the beneficiary with a record of services received and the status of any deductibles. The MSN also informs the beneficiary of appeal rights. The Balanced Budget Act of 1997 requires all Part A benefit notices to include the amount of Medicare payment for each service. Intermediaries and carriers (including RHHIs and DMERCs) must furnish an MSN to all beneficiaries for whom claims are filed during the month unless the situation is specifically excluded by other manual instructions. *Contractors shall issue No-Pay MSNs on a quarterly/90 day mailing cycle. MSNs with a payment check to the beneficiary shall continue to be mailed out as processed. No–pay MSNs are defined as those MSNs which do not require payment to the beneficiary for the respective claim(s).*

The MSN replaced the following documents:

- Form CMS-1533, Part A Medicare Benefit Notice, also known as the Part A Notice of Utilization (NOU) sent for inpatient services;
- Form CMS-1954, Benefit Denial Letter (BDL), sent for partially denied claims; and
- Form CMS-1955, BDL sent for totally denied claims.

Since CMS eliminated BDLs, Medicare beneficiaries receive the information previously conveyed on BDLs through narrative messages contained on the MSN. Providers no longer receive a separate written notification or copy of the BDL. Providers must utilize the coding information (e.g., ANSI Reason Codes) conveyed on the financial remittance advice to ascertain reasons associated with Medicare claims determinations affecting payment and applicable appeal rights and/or appeals information.

B. Carrier/DMERC MSN

The MSN is used to notify Medicare beneficiaries of action taken on their processed claims. The MSN provides the beneficiary with a record of services received and the status of any deductibles. The MSN also informs the beneficiary of appeal rights.

10.3.1 - General Requirements - MSN

(Rev. 955, Issued: 05-19-06, Effective: MCS-June 12, 2006, VMS-July 1, 2006, FISS-September 1, 2006; Implementation: MCS-June 12, 2006, VMS-July 3, 2006, FISS-September 1, 2006)

The MSN is specifically designed as a summary notice to beneficiaries. Providers receive a summary voucher and check. Intermediaries send MSN notices to beneficiaries for outpatient and inpatient claims combined in one notice. *Contractors shall issue No-Pay MSNs on a quarterly/90 day mailing cycle. MSNs with payment checks to the beneficiary shall continue to be mailed out as processed. No–pay MSNs are defined as those MSNs which do not require payment to the beneficiary for the respective claim(s).*Carriers send notices for unassigned claims and assigned claims with payment due to the beneficiary as they are processed or according to their present schedule.

When requested by the quality assurance (QA) staff, contractors produce an exact copy of the MSN sent to the beneficiary for QA reviews. If the beneficiary requests a replacement copy, the contractor must be able to produce an exact copy as it was originally generated or produce an MSN containing only the claim requested by the beneficiary, even though it may have been part of a summary. The beneficiary's request will determine the type of copy that the contractor sends.

Copies for claims processed prior to the MSN format can be produced in the MSN format. Contractors must also generate an MSN upon beneficiary request for previously suppressed claim information.

Contractors must have the capability to issue the MSN in Spanish, if the beneficiary requests this. To assess beneficiary preference for a Spanish MSN, contractors may print a message in the General Information section in both Spanish and English, which tells beneficiaries that they can receive the MSN in Spanish if they desire.

Contractors also:

Generate by computer the entire front of the form; and

Preprint or generate by computer the back of the form.

To the extent that contractors have the capability to perform duplex printing, they must exercise that option.

To ensure all claims processing messages are uniform throughout the Medicare program, contractors do not use locally developed claims processing messages until approved and assigned a number by central office. Contractors send draft claims processing messages for preliminary review to their RO along with an explanation of necessity. Regional offices now have the authority to approve local General Information and "Help Stop Fraud" messages.

Carriers and intermediaries are required to include a “Help Stop Fraud” message every 6 months.

Language must be approved by the RO. Contractors send draft messages for review to their RO along with an explanation of necessity. The RO will review the messages and respond.

The “Help Stop Fraud” section is designed for varying “Help Stop Fraud” messages, which can be found in §50.24, and/or to alert beneficiaries of local fraud scams. For example, if a contractor knows of someone offering free cheese and milk in exchange for Medicare numbers, it can design a message telling beneficiaries to be extra careful. Since space is limited in the “Help Stop Fraud” section, the contractor can use the “General Information” section for lengthy messages. If it uses those messages provided in §50.24, it should review its message every six months to determine if a more appropriate message could be used. “Help Stop Fraud” messages may be changed as often as necessary, as long as they are timely and current. Messages that pertain to local fraud scams need only be approved at the RO level. General “Help Stop Fraud” messages that contractors develop, similar in content to those listed in §50.24, must be approved by CMS.

The “General Information” section is designed to inform beneficiaries of local health fairs and Medicare seminars, as well as those messages in §50.24, and those mandated by CMS. Messages that pertain to local events need be approved only at the RO level. “General Information” messages that carriers develop, similar in content to those listed in §50.24, must be approved by CO through the RO.

Sample exhibits are provided in §50.24. These samples are referenced throughout the text. In the event of a discrepancy, the written instructions take precedence over the exhibits.

10.3.6 - Claims Information Section

(Rev. 955, Issued: 05-19-06, Effective: MCS-June 12, 2006, VMS-July 1, 2006, FISS-September 1, 2006; Implementation: MCS-June 12, 2006, VMS-July 3, 2006, FISS-September 1, 2006)

A. General Information About the "Claims Information" Section

The claims information section contains the following elements:

- For Intermediaries:
    - Program Status Line ("Part A Hospital Insurance - Inpatient Claims" or "Part B Medical Insurance - Outpatient Facility Claims" or "Home Health Facility Claims" or "Hospice Facility Claims"
    - Column Headings
    - Claim Number
    - Provider's Name and Address
    - Attending/referring Physician's Name
    - Service Line Details
    - Claims Totals
    - Alphabetic Codes for "Notes"
    - The name and address of the billing provider includes the provider's name and complete address. Below the billing provider's name and address, if applicable, show "referred by the full name of the attending physician.
    - Claims should be displayed by billing provider in alphabetic order.
    - For multiple claims from one billing provider, sort claims chronologically by service
    - Use standard abbreviation of Revenue Codes provider by the National Uniform Billing Committee and do not change wording.
    - If HCPCS are shown, use short description of services provided by CMS. If the descriptor is used, do not show the revenue code descriptor.
- For Carriers - Part B Medical Insurance:

  Except for the header and the provider name(s) and address(es), which are fixed, the data in Area II can vary in length. Area II contains the following elements:
    - Control number(s),
    - Provider name(s) and address(es),

- Service or line item detail, and
- Alphabetic note codes.

B. Technical Specifications for "Claims Information" Section

For Intermediaries:

Program Status Line

- For inpatient claims print "PART A HOSPITAL INSURANCE - INPATIENT CLAIMS" in uppercase equivalent to 12-point bold type;
- For outpatient claims, print "PART B MEDICAL INSURANCE - OUTPATIENT FACILITY CLAIMS" in uppercase equivalent to 12-point bold type;
- For Home Health Part A claims, print "PART A - HOME HEALTH FACILITY CLAIMS";
- For hospice claims, print "Part A - HOSPICE FACILITY CLAIMS."

Allow equivalent to 10-point blank line.

Print a box equivalent to a 1-point line around the following claims information. The box will be variable in length depending on the number of claims displayed. There is a 1-byte margin between the claims information box line and the beginning and ending of printed information. There is a 1-byte space between columns. Print the column headings in mixed case type, equivalent to 10-point bold type, using 3 lines as in the exhibits.

Dates of Service - The "Dates of Service" column is 17 bytes wide. Center the column heading within the first 7 bytes.

Services Provided - Use for outpatient claims only. The "Services Provided" column is 45 bytes wide. Print the column heading flush left in the column.

Number of Services Provided - Use for Home Health claims. The "Number of Services Provided" column is 45 bytes wide. Print the column heading flush left in the column.

Benefit Days Used - Use for inpatient claims only. The "Benefit Days Used" column is 11 bytes wide. Print the column flush right.

Amount Charged - Used for Outpatient and Home Health Claims Only - The "Amount Charged" column is 11 bytes wide. Print the column heading flush right in the column.

Noncovered Charges - The "Noncovered Charges" column is 11 bytes wide. Print the column heading flush right in the column.

Deductible and Coinsurance - Used for Inpatient and Outpatient Claims - The "Deductible and Coinsurance" column is 10 bytes wide. Center the column heading. (For Home Health claims, the title is "Coinsurance").

You May Be Billed - The "You May Be Billed" column is 10 bytes wide. Center the column heading.

See Notes Section - The "See Notes Section" is 7 bytes wide. Center the column heading.

Print a horizontal equivalent to 1-point line extending from left to right margin between the column headings and the claim(s) information.

Allow equivalent to 10-point blank line.

Print claim information within the box as follows:

- The claim number spans the "Dates of Service" and "Services Provided" columns. Do not extend information into the "Amount Charged" column.
    - Print "Claim number" in mixed case equivalent to 10-point mixed case followed by the actual claim number on the line directly above the provider name and address.
- The provider information spans the "Dates of Service" and "Services Provided" columns. Do not extend information into the "Amount Charged" column.
    - Print the billing provider name and mailing address in mixed case equivalent to 10-point bold type. Billing provider name and address should be separated by commas. Use the physical address of the billing provider if it is different from the mailing address. If possible, print this information on one line. Additional lines, if necessary, should be indented five bytes. For carriers, when using degree (e.g. M.D.) with provider name, place a period after the "M" and after the "D."
    - Print "Referred by:" followed by the attending physician's name and degree (if applicable) in mixed case equivalent to 10-point type. When printing degree (e.g., M.D.) with provider name, place a period after the "M" and after the "D." Referring physician name and degree should be separated by a comma. If the UPIN submitted on the claim is not on file, use the name as shown on the claim. Suppress the "Referred by:" line if not able to identify the doctor. For carriers, if the referring physician is the same as any performing physician on the claim, suppress the referring physician line. If the UPIN submitted on the claim is not on the contractor's file, suppress the "Referred by:" line. For clinic or group practice billing, print the performing physician's name in mixed case equivalent to 10-point type immediately before the services the physician performed.

- Dates of Service - Print service line dates in mm/dd/yyyy format in “Dates of Service” column in mixed case equivalent to 10-point type, left justified. If services extend over several days, use a hyphen or dash to show the extension (mm/dd/yyyy - mm/dd/yyyy).

- The “Services Provided” column contains the HCPCS short descriptor in mixed case equivalent to 10-point type followed by code in parenthesis or revenue code descriptor. If no HCPCS code is present, show the revenue code standard abbreviation as defined by the National Uniform Billing Committee, left justified (bytes 1-47 are reserved for these descriptions). Print each service description on no more than 1 line, on the same line horizontally as the date of service.

- Number of Services Provided - The “Number of Services Provided” column is the revenue code standard abbreviation as defined by the National Uniform Billing Committee, preceded by the number of units, both of which are in mixed case to 10 point type. If a HCPCS code is present, the HCPCS short descriptor will be used. Left justify (bytes 1-45 are reserved for this element). Print each “Number of Services Provided” in no more than one line, on the same line horizontally as the “Date of Service.”

- Benefit Days Used - This column will show the number of days used during the hospital or skilled nursing facility admission (i.e., 12 days) Use case equivalent to 10 point type. Left justify (bytes 1-11 are reserved for this). Print each “Benefit days Used” in no more than one line on the same line horizontally as “Date of Service.”

- Align all dollar amounts appearing in the “Claim Information Box” by decimal. For zero dollar amounts, show “0.00.” Print all dollar amounts in mixed case equivalent type.

- Amount Charged - Show the submitted charge for each service line. Print a dollar sign on the first service line. Right justify all charges. This detail is not shown on Part A inpatient (hospital or SNF) claims. Print in mixed case equivalent to 10-point type.

- Noncovered Charges - Show the noncovered amount for each service line. Print a dollar sign on the first service line. Right justify all charges. Noncovered services will include beneficiary liable as well as provider liable charges.

- Deductible and Coinsurance - Show the “Deductible and Coinsurance” applicable for each service line. Print a dollar sign on the first service line. Right justify all amounts. Carriers show deductible and coinsurance with a message in the “Notes” section.

- You May Be Billed - Show the beneficiary liability for each service line. Print a dollar sign on the first service line. Right justify all amounts. Print in mixed case equivalent to 10-point type.

- See Notes Section - Enter lowercase “a” for the first item that requires an explanation. Place “a” and the appropriate message from §50 in the “See Notes Section” box. If the same message is needed for more than one claim or service line, print the same alphabetic code each time the message is required on the MSN. Print alphabetic codes in mixed case equivalent to 10-point type.

    - If the contractor’s system provides a second message for the same item, print the letter “b” in lowercase equivalent to 10-point type preceded by a comma. Show no more than three alphabetic codes per line.

    - For all remaining claims on the MSN, if a claim or service line requires a message, use the next available lowercase alphabetic code.

    - Print alphabetic codes for claim level notes in bold in the “See Notes Section” column on the same line as the billing provider’s name. The next 3 codes will be directly below the first 3, which places them on the same line as the billing provider’s street address. Print alphabetic codes for service lines in the “See Notes Section” column on the same line as the service. If more than 3 codes for line level, print on the next line below. Print alphabetic codes flush left. If more than 26 lower case alphabetic codes are used, begin using uppercase alphabetic codes.

- Claim Total Line - Indent 12 bytes and print in mixed case type equivalent to 10-point bold “Claim Total.” Print the “Claim Total” line only for claims with more than one service line.

    - Total the amounts in each column and print the sum right justified and equivalent to 10-point bold type. Print a dollar sign preceding the total in each column. The total amount in the “Medicare Paid You” column includes all interest paid to the beneficiary for that claim.

- Print a horizontal line 1/16-inch wide in 20 percent shading extending from left to right margin on the claim information box. Print this shaded line between each claim shown on the MSN. Do not print the shaded line under the last claim displayed in the “Claims Information Section.” Do not print the shaded line if only one claim is displayed on the MSN.

For Carriers:

Carriers print in the following order:

1. Horizontal line (0.048” wide extending from left to right margin).

2. In 10 point bold type, show “Details about this notice. (See the back for more information.)” Print this text in 10% shading.

3. Horizontal line (0.008” wide extending from left to right margin).

4. Display the provider name(s) and address(es), control number(s) (break control numbers into segments (see sample)), headings, and service detail according to the rules described below. The length and appearance of the service display will vary according to whether the EOMB is for an assigned or unassigned claim. Print all of this information in 10 point type and bold where indicated.

   For assigned claims (one billing provider, possibility of multiple control numbers), print, under the horizontal line, the following information in this order:

   - "BILL SUBMITTED BY:", in all uppercase letters in 10 point bold type;
   - On the same line starting one half inch beyond the end of "BILL SUBMITTED BY:", print the name of the provider. When using "M.D." with the provider name, place a period after the "M" and after the "D."
   - Directly underneath the words "BILL SUBMITTED BY:" print the words "Mailing address:" Print the address directly underneath the name of the provider and on a single line, if possible.
   - If the service was provided at a clinic/group practice that bills for its physicians, show the clinic/group practice name; and
   - If a solo practicing physician performed the service(s), show his/her name and complete mailing address.

For clinic/group practice billing, show the performing physician's name as follows:

- Blank line;
- Print the following headings in 10 point bold:
  - Dates;
  - Services and Service Codes;
  - Charge;
  - Medicare Approved; and
  - See Notes Below.

Print the "Dates" heading aligned with the left margin. Print the "Services and Service Codes" heading aligned with the provider name and mailing address. Use appropriate spacing as shown in Exhibits 1, 2, and 3 to print the remaining headings on the same line.

The information printed under each heading is described later in this section.

- Control number in 10 point bold type;
- Performing physician's full name in 10 point bold type;
- Service items for performing physician;

- Blank line;

- If there is only one control number and one provider: after all of the service items have been listed, sum the charged and approved amounts to derive a total. Print a "+" beside the "charge" and "approved" amounts of the last line item and underline. Print "Total" in 10 point bold type face aligned with the left edge of the summary box found in area I and print the totals for the "Charge" and "Medicare Approved" columns. A "$" is printed before each dollar total.

Use the totals of the "Charge" and "Medicare Approved" columns in the summary block in Area I. Also, use the total "Medicare Approved" amount in Area IV.

Suppress "Total" if only one line item appears on the EOMB. There is no need to total one line item.

NOTE: For multiple control numbers and providers, do not follow the directions in number 8. until all control numbers, providers, and service items have been listed. For multiple performing physicians under the same control number, repeat numbers 5., 6., and 7. until all performing physicians' names and service items have been listed. For multiple control numbers, repeat numbers 4., 5., 6., and 7. until the performing physicians names and service items for all control numbers have been printed. After the last provider's services have been listed for the last control number, sum the charged and approved amounts. Do not leave a blank line between the last service item and the "Total."

For unassigned claims (one control number, possibility of multiple providers), print, under the horizontal line, the following information in this order:

- Control number in 10 point bold type;

- Blank line;

- "BILL SUBMITTED BY:", in all uppercase letters in 10 point bold type;

- On the same line, one half inch beyond the end of "BILL SUBMITTED BY:", print the name of the physician/supplier providing the medical service or supplies. Directly beneath the words "BILL SUBMITTED BY:" print the heading: "Mailing address:". Print the mailing address directly underneath the name of the physician/supplier. Print this information in no more than two lines.

- If the service was provided at a clinic/group practice that bills for its physicians, show the clinic/group practice name; and

- If a solo practicing physician performed the services, show his/her name and complete mailing address.

For clinic/group practice billing, show the performing physician's name immediately before the services he/she performed in 10 point bold type as directed below. If the

system does not carry the clinic/group name for unassigned claims, show the performing provider's name in place of the clinic/group name followed by the clinic/group address.

- Blank line.
- Print the following headings in 10 point bold underlined:
    - Services and Service Codes,
    - Dates,
    - Charge,
    - Medicare Approved, and
    - See Notes Below.

Print the "Dates" heading aligned with the left margin. Print the "Services and Service Codes" heading aligned with the provider/supplier name and address. Use appropriate spacing as shown in Exhibits 1, 2 and 3 to print the remaining headings on the same line.

The information printed under each heading is described later in this section.

- Print the performing physician's name in 10 point bold type if the provider is a clinic. List all service items in chronological order for that physician. For each performing physician billed by a clinic, list his/her name in 10 point bold type followed on the next line by the service item(s). Generally there is only one provider. If so, after all of the service items have been listed, sum the charged and approved amounts to derive a total. Print a "+" beside the "charge" and "approved" amounts of the last line item and underline. Print "Total" in 10 point bold type face aligned with the left edge of the area I summary box and print the totals for the "Charge" and "Medicare Approved" columns. Print a "$" before each dollar total.

Use the totals of the "Charge" and "Medicare Approved" columns in the summary block in Area I. Also, use the total "Medicare Approved" amount in Area IV.

Suppress "Total" if only one line item appears on the MSN. There is no need to total one line item.

NOTE 1: For multiple providers (when beneficiaries submit claims, see Note 2), do not print the totals until all providers and service items have been listed. For each provider, print the information shown above for unassigned claims. After the last provider's services have been listed, sum the charge and approved amounts. Do not leave a blank line between the last service item and "Total".

NOTE 2: Unassigned claims are submitted by providers and should, therefore, be one claim to one EOMB. However, produce an EOMB showing multiple providers when beneficiaries have submitted claims. Generate these when:

- Services were provided before September 1, 1990;
- Services were not covered by Medicare and beneficiaries want a formal coverage determination;
- Physicians or suppliers refuse to submit claims for services on or after September 1, 1990;
- Services were provided outside the United States;
- Used DME is purchased from a private source; or
- Medicare is secondary payer.

- Aligned with the left margin, print the following statement in 10 point bold type: "Your provider(s) did not accept assignment. We are paying you the amount that we owe you. See #4 on the back." (NOTE: print this statement on a single line preceded by a blank line). Do not print the "We are paying you the amount that we owe you" portion of the message when no payment is made.

The data printed under each of the headings mentioned above are described here. Print each service, code, date, charge, approved amount and notes on one line.

The "Services Provided" column contains the number of services, HCPCS code short descriptor, procedure code, and modifiers. Print in mixed case equivalent to 10-point type. The first 3 bytes are fixed and reserved for the number of services. Right justify the number of services within these 3 bytes. Byte 4 is a space. Bytes 5 through 47 are reserved for the HCPCS short descriptors, procedure codes and modifiers. Print each service description in no more than 1 line in mixed case equivalent to 10-point type. Follow the descriptor by procedure code, and modifier(s) if necessary, in parentheses. The carrier separates procedure codes and modifiers with a dash.

Print the following modifier descriptors on the next line when applicable. When printing a modifier descriptor, drop the procedure code and its modifier(s) to the line with the modifier descriptor. Begin printing the procedure code directly under the short descriptor. The modifier descriptor should follow immediately after the procedure code.

Services and applicable modification codes and descriptions are shown in the following table.

Service	**Modifier Code**	**Modifier Description on MSN(s)**
Assistant surgery	80, 81, and 82	Assistant surgeon
Professional component	26	Professional charge
Technical component	TC	Technical charge

Service	Modifier Code	Modifier Description on MSN(s)
DME rental	RR	Rental
DME purchase	NR	Purchase
DME maintenance/service	MS	Maintenance/service
DME replacement/repair	RP	Replacement/repair
Post-op care	55	Care after operation
Pre-op care	56	Care before operation
Ambulatory surgical center fees	SG	Surgery center fee

NOTE FOR DMERCS: If there are three or more modifiers, drop the procedure code and its modifiers to the next line. Begin printing the procedure directly under the short descriptor. The modifier descriptor should follow immediately after the procedure code.

Dates - Use the first three letters of the month name as a three letter abbreviation for the month. If the services extended over several days or into the following month, use a "-" to show the extension.

Charges - Show submitted charge(s). Print the dollar sign on the first line. After of the service items have been listed, sum the charges to derive a total. Print a "+" beside the charge for the last line item and underline.

Medicare Approved - Show the fee schedule amount or approved charge. For claims involving psychiatric outpatient services, print the approved amount before the psychiatric reduction. Print the dollar sign on the first line. After all of the service items are printed, sum the charges to derive a total. Print a "+" beside the charge for the last line item and underline.

See Notes Below - Print the heading if there are any explanatory notes. Suppress the heading if the MSN does not require notes.

Enter "a" for the first line item which requires explanation. See §30.2 for a list of the notes to be used on the MSN. Place "a" and the appropriate explanation from §30.2 under "Notes." If another line item is reduced or disallowed for the same reason, also print "a" beside this line item. If the system provides a second explanation for this line item, print the letter "b", preceded by a comma. Enter the explanation from §30.2 in the "Notes" section. Show no more than 5 alphabetic codes and notes per line.

Print notes pertaining to a single line by entering the alphabetic code in the "Notes" column to the right of the line. When there is more than one claim on the MSN, print notes pertaining to a single claim to the right of the claim control number. Print notes pertaining to all claims to the right of the "Total" amount.

- Horizontal line (0.018" wide extending from left to right margin). If Area III starts on a subsequent page, do not print this horizontal line.

Align all dollar amounts appearing in Area II by decimal. For zero dollar amounts, show "0.00".

Additional Claims Information Specifications

- The contractor may split a claim between pages if the claim is more than 10 lines long. If there is insufficient space to print at least 5 lines, do not split the claim. Put the claim on the next page.

- If there is a need to continue the "Claims Information Box" past the first page, print the program status line on the top of continuing pages in the upper left corner below the header, followed by "(continued)" equivalent to 12-point bold lower case type.

- Repeat column headings and line specifications according to the preceding instructions.

- Allow 1 equivalent to 12-point blank line between claims information and beginning of notes section.

- (CARRIERS ONLY): If no "Notes" section is printed, the blank line should precede the section that follows. When a single MSN contains both assigned and unassigned claims, each claim type should be displayed in its appropriate box. The boxes should follow directly after each other. Allow one 12-point blank line between the bottom line of the first box and the assignment status line of the second box. Each box should be created following the specifications in this section. When assigning alphabetic codes for the "See Notes Section" column, if the same message is needed in both the assigned and unassigned claims information boxes, print the same alphabetic code each time the message is required. When a claim in the second claims information box requires a new message, use the next available alphabetic code after the last code used in the preceding box.

- The MSN may be split if more than 99 claims are processed in one 30-day period *or if more than 99 no-pay claims are processed in one 90 day period.*

- Do not print claims denied as duplicates.

50.38 - General Information Section

(Rev. 955, Issued: 05-19-06, Effective: MCS-June 12, 2006, VMS-July 1, 2006, FISS-September 1, 2006; Implementation: MCS-June 12, 2006, VMS-July 3, 2006, FISS-September 1, 2006)

38.3 - If you change your address, contact the Social Security Administration by calling 1-800-772-1213.

38.4 - You are at high risk for complications from the flu and it is very important that you get vaccinated. Contact your health care provider for the flu vaccine.

38.5 - If you have not received your flu vaccine it is not too late. Contact your health care provider about getting the vaccine.

38.6 - January is cervical cancer prevention month.

38.7 - The Pap test is the most effective way to screen for cervical cancer.

38.8 - Medicare helps pay for screening Pap tests once every two years.

38.9 - Colorectal cancer is the second leading cancer killer in the United States. However, screening tests can find polyps before they become cancerous. They can also find cancer early when treatment works best. Medicare helps pay for screening tests. Talk to your doctor about the screening options that are right for you.

38.10 - Compare the services you receive with those that appear on your Medicare Summary Notice. If you have questions, call your doctor or provider. If you feel further investigation is needed due to possible fraud or abuse, call the phone number in the Customer Service Information Box.

38.12 - Your physician participates in the Competitive Acquisition Program for Medicare Part B drugs (CAP. The drug(s) you received in your physician's office were provided by an approved CAP vendor. You will receive two separate Medicare Summary Notices (MSNs). This MSN is from the Medicare carrier that processes claims for your drug that came from the approved CAP vendor. You will receive another MSN from the Medicare carrier that processes claims for your physician, for the administration of the drug(s). If you appeal the determination for this drug vendor claim, you must send your appeal to the Medicare carrier address listed on the physician administration MSN, and not this vendor claim MSN.

38.13 - If you are not due a payment check from Medicare, your Medicare Summary Notices (MSN) will now be mailed to you on a quarterly basis. You will no longer receive a monthly statement in the mail for these types of MSNs. You will now receive a statement every 90 days summarizing all of your Medicare claims. You may receive a bill from your provider before you receive an MSN. Compare the MSN with the bill from your provider to ensure you paid the appropriate amount for your services.

90.38 - Sección De Información General

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38.3 - Si usted cambia de dirección, por favor comuníquese con la Administración del Seguro Social al 1-800-772-1213.

38.4 - Usted está en alto riesgo para complicaciones de la influenza y es muy importante que usted se vacune. Favor de comunicarse con su proveedor del cuidado de la salud para la vacuna contra la influenza.

38.5 - Si usted no ha recibido su vacuna contra la influenza no es demasiado tarde. Favor de comunicarse con su proveedor del cuidado de la salud sobre recibir la vacuna contra la influenza.

38.6 - El cáncer colorectal es el segundo cáncer principal que ataca en los E.E.U.U. Sin embargo, pruebas de investigación pueden encontrar pólipos antes de que lleguen a ser cancerosos. También pueden encontrar el cáncer temprano cuando el tratamiento trabaja lo mejor posible. Medicare ayuda a pagar por pruebas de investigación. Comuníquese con su doctor sobre las opciones de pruebas de investigación que son apropiadas para usted.

38.7 - Medicare cubre las pruebas de investigación del cáncer colorectal que pueden encontrar pólipos precancerosos en el colon y recto. Los pólipos pueden ser removidos antes de que sean cancerosos. Comuníquese con su doctor sobre hacerse la prueba.

38.8 - Enero es el mes de la prevención del cáncer cervical.

38.9 - La prueba de papanicolao (o prueba pap) es la manera más efectiva de examinar el cáncer cervical.

38.10 - Compare los servicios que usted recibe con los que aparecen en su Resumen de Medicare. Si tiene preguntas, llame a su doctor o proveedor. Si usted cree que se necesita investigar más debido a un posible fraude o abuso, llame al teléfono que aparece en la sección Información de Servicios al Cliente.

38.12 – Su médico participa en el Programa de Adquisición Competitiva para las medicinas cubiertas por la Parte B de Medicare (CAP, por sus siglas en inglés). Las medicinas que usted recibió en la oficina de su médico fueron provistas por un suplidor autorizado del CAP. Usted recibirá dos Resúmenes de Medicare por separado. Este Resumen es de la empresa de seguros Medicare que procesa las reclamaciones de sus medicinas provistas por el suplidor autorizado del CAP. Usted recibirá otro Resumen de la empresa de seguros Medicare que procesa las reclamaciones de su médico, por el suministro de sus medicinas. Si usted apela la decisión de esta reclamación del suplidor de medicinas, debe enviar la apelación a la empresa de seguros Medicare que se

menciona en el Resumen de la reclamación de su médico y no a la dirección que aparece en este Resumen.

38.13 - Si Medicare no le debe un pago por cheque, sus Resúmenes de Medicare (MSN, por sus siglas en inglés) serán enviados por correo cada tres meses. Usted no recibirá un resumen mensual en su correo si Medicare no le debe un pago por cheque. De ahora en adelante, usted recibirá un aviso como éste (que no incluye pago por cheque) cada 90 días resumiendo todas sus reclamaciones de Medicare. Usted puede recibir una factura de su proveedor antes de que reciba un aviso de MSN. Compare el MSN con la factura que le envió su proveedor para asegurarse de que pagó la cantidad correcta por sus servicios.