

TO: ALL PROVIDERS

FROM: CAREFIRST OF MARYLAND INC., MEDICARE PART A

DATE: SEPTEMBER 13, 2004

SUBJECT: SHOULD CONDITION CODES 20, 21 OR OCCURRENCE CODE 32 BE USED?

Beneficiaries are assumed to be liable on claims using condition code 21, since these claims, sometimes called “no-pay bills” and having all non-covered charges, are submitted to Medicare to obtain a denial that can be passed to subsequent payers. An advance beneficiary notice (ABN) is not required in these cases. If an ABN is given, condition code 21 cannot be used.

Claims with condition code 20 may be submitted with both covered and non-covered charges. An ABN should not be employed when condition code 20 is used. Claims are billed with condition code 20 at the beneficiary's request, where the provider has already advised the beneficiary that Medicare is not likely to cover the service (s) in question. Providers may directly collect payment from beneficiaries in such cases for non-covered charges, but if, upon review, Medicare decides a service in question is actually covered and pays, providers must return any payment collected from beneficiaries for these services.

Occurrence code 32 on a claim signifies that an ABN was given to a beneficiary on a specific date. This code must be employed if this specific ABN is given, and condition code 20 will not be used on the subsequent claim (i.e., **no charges will be billed as non-covered**). All services on such claims with occurrence code 32 must be covered charges, even if the result of full adjudication of these claims is expected to be that services will be found to be non-covered. If such services are non-covered after full adjudication, the beneficiary remains liable for the services. If instead, as a result of medical review, Medicare finds services are covered, the Medicare Program becomes liable since the provider will receive payment direct from Medicare.

Only services for which the ABN was given should be shown on the claim with occurrence code 32, since the code pertains to every service on the claim. Providers must give separate ABNs for different procedures if performed on different dates, and show the services and the dates ABNs were given on separate bills for each date involved.

If a service not pertaining to an ABN was rendered in the same period as service(s) requiring an ABN, such services must be submitted on separate claims, and the statement dates of these claims cannot overlap. If the time periods cannot be separated (i.e., a service requiring an ABN is given on the same day a service not requiring an ABN), a single claim must be submitted, just for the overlapping period, using occurrence code

32, showing all services as covered, and placing modifier GA on the HCPCS code to identify the service (revenue code) line for which the ABN was given. Since this is an exception process, providers are reminded to use this mechanism only when it is impossible to separate the billing periods.

The final instance in which beneficiaries are liable for non-covered charges is for services they request be billed to Medicare, but Medicare does not cover by statute. Examples of services not covered by statute include personal comfort items, hearing aides and hearing examinations, routine eye and dental care. Providers should advise beneficiaries each time they are aware services not covered by statute are being requested before Medicare is billed, but ABNs are not to be used in these cases.

If, in a situation in which giving an ABN is not appropriate, and the beneficiary demands a Medicare determination for any line(s) for other than Home Health (HH) PPS services, the provider is instructed to put those line(s) on a separate claim showing the charges as non-covered and put condition code 20 on the bill. If a beneficiary wants an MSN for denial reasons on any line(s), providers are instructed to put those lines(s) on a separate claim and show condition code 21 on that bill. If the provider gives the beneficiary an ABN under any other circumstances, the provider must show the charges as covered and also put occurrence code 32 on the claim to affix beneficiary liability. There are no provider billing requirements for billing services excluded by statute other than billing such items as non-covered.

(See Change Request 3115, Transmittal 133 for complete billing instructions related to the billing of non-covered charges).

Questions regarding this bulletin should be directed to the Provider Relations Department at 1-866-488-0545.

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