CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 13272	**Date: June 18, 2025**
	Change Request 13903

Transmittal 13011 issued December 20, 2024, is being rescinded and replaced by Transmittal 13272, dated June 18, 2025, to remove the MLN article requirement for this CR from both publications 100-02 and 100-04. All other information remains the same.

SUBJECT: Updates to No Legal Obligation to Pay for or Provide Services and Examples of Application of Government Entity Exclusion (Pub. 100-02, chapter 16, sections 40 and 50.3.3 and newly created section 40.7) and Claims Submitted for Items or Services Furnished to Medicare Beneficiaries in State or Local Custody Under a Penal Authority (Pub. 100-04, chapter 1, section 10.4)

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update the internet only manual to make it consistent with our regulations. In the CY 2025 OPPS rule, CMS clarified its regulations at 42 CFR 411.4(b) by stating that for purposes of Medicare payment, an individual is considered to be in the custody of a penal authority if the individual is:

(A) Incarcerated in a jail, prison, penitentiary, or similar institution;

(B) Temporarily outside of a jail, prison, penitentiary, or similar institution on medical furlough or similar arrangement;

(C) Escaped from confinement by a penal authority; or

(D) Required to reside in a mental health facility under a penal statute or rule.

Individuals who are not considered to be in the custody of a penal authority include, but are not limited to, individuals who are—

(A) Released to the community pending trial (including those in pretrial community supervision and those released pursuant to cash bail);

(B) On parole;

(C) On probation;

(D) On home detention or home confinement; or

(E) Required to live in a halfway house or other community-based transitional facility.

Therefore, as a result of the changes to our regulations, CMS is amending Pub. 100-02, chapter 16, sections 40 and 50.3.3, and creating new section 40.7. CMS is amending Pub. 100-04, chapter 1, section 10.4 of the Internet Only Manual in order to make them consistent with 42 CFR 411.4(b).

EFFECTIVE DATE: January 1, 2025
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: March 1, 2025

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: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	1/10.4/Claims Submitted for Items or Services Furnished to Medicare Beneficiaries in State or Local Custody Under a Penal Authority

III. FUNDING:

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 13272	Date: June 18, 2025	Change Request: 13903

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Therefore, as a result of the changes to our regulations, CMS is amending Pub. 100-02, chapter 16, sections 40 and 50.3.3, and creating new section 40.7. CMS is amending Pub. 100-04, chapter 1, section 10.4 of the Internet Only Manual in order to make them consistent with 42 CFR 411.4(b).

II. GENERAL INFORMATION

A. Background: Section 1862(a)(2) of the Social Security Act ("the Act") prohibits Medicare payment under Part A or Part B for any expenses incurred for items or services for which the individual furnished such items or services has no legal obligation to pay, and which no other person (by reason of such individual's membership in a prepayment plan or otherwise) has a legal obligation to provide or pay for, except in the case of Federally qualified health center services. Also, under Section 1862(a)(3) of the Act, if services are paid for directly or indirectly by a governmental entity, Medicare does not pay for the services.

B. Policy: In the CY 2025 OPPS rule, CMS clarified its regulations at 42 CFR 411.4(b) by stating that for purposes of Medicare payment, an individual is considered to be in the custody of a penal authority if the individual is:

(A) Incarcerated in a jail, prison, penitentiary, or similar institution;

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Therefore, as a result of the changes to our regulations, CMS is amending Pub. 100-04, chapter 1, section 10.4 of the Internet Only Manual in order to make them consistent with 42 CFR 411.4(b).

III. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
13903 - 04.1	Contractors shall refer to Pub. 100-04, chapter 1, section 10.4 for information regarding Medicare's no legal obligation to pay and governmental entity payment exclusions.	X	X	X	X					

IV. PROVIDER EDUCATION

None

Impacted Contractors: None

V. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

VI. CONTACTS

Pre-Implementation Contact(s): Fred Grabau, frederick.grabau@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VII. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

Medicare Claims Processing Manual
Chapter 1 - General Billing Requirements

Table of Contents
(Rev. 13272; Issued: 06-18-25)

70.8.6.1 – Monitoring Claims Submission Violations
(Rev. 13272; Issued:06-18-25; Effective:01-01-25; Implementation:03-01-25)

A. General

Section 1848(g)(4) of the Social Security Act requires physicians and suppliers to submit claims to Medicare carriers for services furnished on or after September 1, 1990. It also prohibits physicians and suppliers from imposing a charge for completing and submitting a claim. Physicians and suppliers who fail to submit a claim or who impose a charge for completing the claim are subject to sanctions. CMS is responsible for assessing sanctions and monetary penalties for noncompliance.

Physicians and suppliers are not required to take assignment of Medicare benefits unless they are enrolled in the Medicare Participating Physician and Supplier Program or, in the case of physician services, the Medicare beneficiary is also a recipient of State medical assistance (Medicaid) or the service is otherwise subject to mandatory assignment.

B. Compliance Monitoring

To ensure that providers and suppliers are enrolled in the Medicare program and submit claims in compliance with the mandatory claims submission requirements found in §1848(g)(4) of the Social Security Act, contractors shall:

1) *Process beneficiary claims submitted to A/B MACs or carriers for services that are <u>not</u> covered by Medicare (e.g., for hearing aids, cosmetic surgery, personal comfort services, etc.; see 42 CFR 411.15 for details), in accordance with its normal processing procedures;*

2) *Process beneficiary claims submitted to A/B MACs or carriers for services that are covered by Medicare and the beneficiary has submitted a complete and valid claim (Form CMS-1490S) <u>and</u> all supporting documentation associated with the claim, including an itemized bill with the following information:*

   - *Date of service,*
   - *Place of service,*
   - *Description of illness or injury,*
   - *Description of each surgical or medical service or supply furnished,*
   - *Charge for each service,*
   - *The doctor's or supplier's name and address,*
   - *The provider or supplier's National Provider Identifier (NPI)*
   - *The ordering & referring provider's legal name and address and the National Provider Identifier (NPI) if known when the itemized bill is from:*

     A Clinical laboratory for ordered tests
     An independent diagnostic imaging center for ordered imaging procedures
     A supplier of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) for ordered DMEPOS

   If the beneficiary furnishes all other information but fails to supply the provider or supplier's NPI the contractor shall not return the claim but rather look up the provider or supplier's NPI using the NPI registry. If the contractor determines that the provider or supplier was not a Medicare enrolled provider with a valid NPI, the contractor shall follow previously established procedures in order to process and adjudicate the claim.

3) *Retain the Form-1490S and supporting documentation and manually return a copy to the beneficiary if it is for a Medicare-covered service and the claim is incomplete, does not include all required supporting documentation and/or contains invalid information. Contractors shall also include an*

appropriate letter that specifically communicates all the items listed above which were missing or invalid. In addition, the CMS-1490S and supporting documentation shall be maintained for purposes of the timely filing rules in the event that the beneficiary re-submits the claim.

If the Beneficiary submits a claim on the English or Spanish Form CMS-1490S (version 01/05) on or after April 1, 2019, manually return the Form CMS-1490S (version 01/05) claim to the beneficiary, and include a copy of the Form CMS-1490S (version 01/18), along with a letter instructing the beneficiary to complete and return the Form CMS-1490S (version 01/18) for processing within the time period prescribed in §70.5.

If a beneficiary submits a claim on the Form CMS-1500, manually return the Form CMS-1500 claim to the beneficiary, and include a copy of the Form CMS-1490S, along with a letter instructing the beneficiary to complete and return the Form CMS-1490S for processing within the time period prescribed in §70.5, above. Include in the letter a description of missing, invalid or incomplete items required for the Form CMS-1490S that were not included with the submitted Form CMS-1500 or were invalid.

4) *Retain Medicare claims records using the following disposition rules.*

DISPOSITION:

1. Carriers who Microform Claims

a) Hardcopy Records - Cut off no later than the close of the calendar year (CY) in which paid. The hardcopy claim must be retained in accordance with the following:

(1) If a corresponding master microfilm has been made and verified, transfer to a Federally-approved records storage facility or hold onsite. Destroy after a total retention of 3 years after the close of the CY in which paid.

(2) If a corresponding master microform record has NOT been made and verified, transfer to a Federally-approved records storage facility or hold onsite. Destroy after a total retention of 6 years and 3 months after the close of the CY in which paid.

b) Microform Records

The master microform record must be retained for a total retention of 6 years and 3 months following the close of the calendar year in which paid.

2. Carriers Who Do Not Microfilm Claims Records

Cut off at the close of the calendar year (CY) in which paid, then transfer to a Federally-approved records storage facility. Destroy after a total retention of 6 years and 3 months. Earlier cutoff and transfer is authorized. However, the records must be retained for a total retention of 6 years and 3 months following the close of the calendar year in which payment is made.

a) Hardcopy Records - The hardcopy must be retained onsite until the microform has been verified. Cut off at the close of the calendar year in which paid; transfer hardcopy to a Federally-approved records storage facility only if there is a corresponding master microfilm record that can be retained for the period indicated in b. below; otherwise, the hardcopy shall be retained until the 6 years and 3 months period is reached. Earlier cutoff and transfer is authorized. However, the hardcopy must be retained for a total retention of 3 years after the close of the calendar year in which paid.

b) Microform Records - The master microform records must be retained for a total retention of 6 years and 3 months following the close of the calendar year in which payment is made.

When returning a beneficiary submitted claim, the contractor shall inform the beneficiary that the provider or supplier is required by law to submit a claim on behalf of the beneficiary (for services that would otherwise be payable), and that in order to submit the claim, the provider or supplier must enroll in the Medicare program. In addition, contractors shall encourage beneficiaries to always seek non-emergency care from a provider or supplier that is enrolled in the Medicare program.

If a beneficiary receives services from a provider or supplier that refuses to submit a claim to the A/B MAC or carrier, on the beneficiary's behalf, (for services that would otherwise be payable by Medicare), and/or refuses to enroll in the Medicare program, the beneficiary should:

(1) Notify the contractor in writing that the provider or supplier refused to submit a claim to Medicare and/or refused to enroll in Medicare, and

(2) Submit a complete Form CMS-1490S with all supporting documentation.

The contractor shall process and pay the beneficiary's claim if it is for a service that would be payable by Medicare were it not for the provider or supplier's refusal or inability to submit the claim and/or enroll in Medicare. Claims shall be adjudicated based on whether the service provided is covered or non-covered/excluded rather than on the provider's enrollment status. If for a covered service, the claim shall be processed and the allowed amount reimbursed to the beneficiary, if appropriate. If for a non-covered/excluded service, the claim shall be processed and denied with an appropriate MSN message. For sanctioned/excluded and opt-out physicians/practitioners the following MSN messaging is recommended:

Sanctioned/Excluded provider or supplier:

A sanctioned or excluded provider or supplier is an individual or business excluded from participation in the Medicare program for a stated period of time as a result of fraudulent activity, program abuse, or impermissible conduct as determined by OIG. CMS will pay the first claim submitted by a beneficiary for the services of a sanctioned/excluded physician or practitioner and immediately notify the sanctioned/excluded physician or practitioner of the exclusion. CMS will not pay a claim for sanctioned/excluded physician or practitioner services more than 15 days after the date on the notice to the physician or practitioner, or after the effective date of the exclusion, whichever is later. Under no circumstance may Medicare payment be made to any entity, including beneficiaries, for services rendered by such providers or suppliers after the first claim is paid. An example of language that may be considered:

MSN Message 21.27

English
Services provided by a Medicare sanctioned/excluded provider or supplier. No Medicare payment may be made.

Spanish
Los servicios fueron brindado por un proveedor excluído de Medicare, por lo tanto Medicare no pagó por los servicios.

Opt-Out physicians and practitioners:

Medicare payment may be made for the claims submitted by a beneficiary for the services of an opt out physician or practitioner when the physician or practitioner did not privately contract with the beneficiary for services that were not emergency care services or urgent care services and that were furnished no later than 15 days after the date of a notice by the carrier that the physician or practitioner has opted out of Medicare (see 42 C.F.R. 405.435(c)). Therefore, if the beneficiary submits a claim for a service that was furnished by an opt out physician or practitioner, then the carrier must contact the opt out physician or practitioner in order to ascertain whether the beneficiary entered into a private contract with the opt out physician or practitioner. (Note: The carrier should obtain a copy of the private contract from the opt out physician/practitioner before denying the beneficiary's claim if the beneficiary did, in fact, enter into a

private contract with the physician or practitioner.) If the beneficiary did not enter into a private contract with the physician or practitioner and the beneficiary did not receive notice from the carrier that the physician opted out of Medicare, then Medicare payment may be made to the beneficiary for the non-emergency and/or non-urgent care services (assuming that the services would otherwise be payable). On the other hand, if the beneficiary did enter into a private contract with the physician or practitioner for the services or received services from the physician/practitioner 15 days after the date of a notice by the carrier that the physician or practitioner has opted out of Medicare, then no Medicare payment may be made. Medicare has instructed opt out physicians and practitioners that private contract language must include beneficiary instruction precluding the beneficiary from billing Medicare for these services. An example of language that may be considered:

MSN Message 21.26

English
Claim denied because services were provided by an Opt-Out physician or practitioner. No Medicare payment may be made.

Spanish
La reclamación fue denegada porque los servicios fueron brindados por un médico ó proveedor que decidió no participar en Medicare, por lo tanto, Medicare no pagó por los servicios.

Contractors shall maintain documentation of beneficiary complaints involving violations of the mandatory claims submission policy and a list of the top 50 violators, by State, of the mandatory claim submission policy.

Contractors are encouraged to educate providers and suppliers that they must be enrolled in the Medicare program before they submit claims for services furnished or supplied to any Medicare beneficiary.

The above policy, including the NPI requirement, is not applicable for foreign beneficiary claims submitted for covered services. These claims should be processed using guidelines for foreign claims.

The above policy, including the NPI requirement, is not applicable to beneficiary claims submitted to DMEMACs for durable medical equipment, prosthetics, orthotics, and supplies. These claims should be processed by DMEMACs using current procedures.

C. Exception When Physician, Other Practitioner, or Supplier Is Excluded From Participating in Medicare Program

*Section 1848(g)(4) of the Social Security Act requires physicians, other practitioners, or suppliers to submit claims to Medicare carriers for services furnished after September 1, 1990. This **does not** apply to physicians, other practitioners, or suppliers who have been excluded from participating in the Medicare program. Physicians, other practitioners, and suppliers who have been excluded from the Medicare program are prohibited from submitting claims or causing claims to be submitted. See the Medicare Program Integrity Manual for procedures concerning claims submitted by an excluded practitioner, his/her employer, or a beneficiary for services or items provided by an excluded physician, other practitioner, or supplier. Carriers must maintain the systems capability to identify claims submitted by excluded physicians, other practitioners, or suppliers as well as items or services provided, ordered, prescribed, or referred by an excluded party.*

*When an excluded physician, other practitioner, or supplier has not submitted a claim on behalf of the beneficiary and/or the beneficiary has submitted the claim themselves, do **not** send a notification letter to the physician, other practitioner, or supplier warning of civil monetary penalties due to noncompliance with §1848(g)(4)(A) of the Act. Instead, follow the instructions in the Program Integrity Manual.*

70.8.6.2 – Notification Letters
(Rev. 13272; Issued:06-18-25; Effective:01-01-25; Implementation:03-01-25)

A. *The letter sent to the beneficiary should explain why the claim is being returned including an explanation of the corrections needed in order to process the claim. Also, include an explanation of the statutory requirement that providers and suppliers must submit claims for all covered services provided to Medicare beneficiaries. The letter should also provide the beneficiary with instructions on what should be done if the provider or supplier refuses to enroll with Medicare and/or submit the claim.*

B. *A letter shall also be sent to the provider or supplier explaining the statutory requirement for submitting claims for all services rendered to Medicare beneficiaries. The letter should explain to the provider or supplier that they are required to enroll with the Medicare program before a claim can be submitted. Finally the letter should include language explaining the penalties for failure to comply with the mandatory claims submission requirements.*

70.8.6.3 - Violations That Are Not Developed For Referral
(Rev. 13272; Issued:06-18-25; Effective:01-01-25; Implementation:03-01-25)

Claim submission violations need not be developed on beneficiary-submitted Form CMS-1490S claims that include approved charges for services performed on or after September 1, 1990 in the following situations:

- *Used DME purchases from private sources;*

- *Cases in which a physician/supplier does not possess information essential for filing a MSP claim. Assume this is the case if the beneficiary files a MSP claim and encloses the primary insurer's payment determination notice and there is no indication that the service provider was asked to file but refused to do so;*

- *Services paid under the indirect payment procedure;*
- *Foreign claims; and*
- *Other unusual or unique situations that you evaluate on a case-by-case basis.*

NOTE: *It is unlikely that knowing, willful, and repeated noncompliance will apply in the above situations.*