CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1571	Date: AUGUST 7, 2008
	Change Request 5849

This corrects Change Request 5849, dated August 7, 2008. The changes are on the transmittal page, section 20 has been added and in the manual text the effective and implementation dates were transposed, all other material remains the same.

SUBJECT: Transition of Responsibility for Medical Review From Quality Improvement Organizations (QIOs)

I. SUMMARY OF CHANGES: These claims processing instructions are being revised since there is a transition of responsibility for the majority of utilization review from QIOs to Medicare fiscal intermediaries and Medicare administrative contractors. Quality related and some other activities are remaining in the QIO SOW.

NEW / REVISED MATERIAL
EFFECTIVE DATE: AUGUST 1, 2008
IMPLEMENTATION DATE: AS SOON AS POSSIBLE, BUT NO LATER THAN AUGUST 15, 2008

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	3/Table of Contents
R	3/20/Payment Under Prospective Payment System (PPS) Diagnosis Related Groups (DRGs)
R	3/20.1.2/Outliers
R	3/20.1.2.9/Medical Review and Adjustments
R	3/20.2/Computer Programs Used to Support Prospective Payment System
R	3/20.2.1/Medicare Code Editor (MCE)
R	3/40.2.5/Repeat Admissions
R	3/50/Adjustment Bills
R	3/90/Billing Transplant Services

R	3/90.3/Stem Cell Transplantation
R	3/90.4.2/Billing for Liver Transplant and Acquisition Services

III. FUNDING:

SECTION A: For Fiscal Intermediaries and Carriers:
Funding for implementation activities will be provided to contractors through the regular budget process.

SECTION B: 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.

This will be an additional workload to what was awarded to the MAC in their current SOW. A contract modification will be issued to fund this activity. You should coordinate with your contract officer and project officer to address any concerns.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1571	Date: August 7, 2008	Change Request: 5849

This corrects Change Request 5849, dated August 7, 2008. The changes are on the transmittal page, section 20 has been added and in the manual text the effective and implementation dates were transposed, all other material remains the same.

SUBJECT: Transition of Responsibility for Medical Review From Quality Improvement Organizations (QIOs)

Effective Date: August 1, 2008
Implementation Date: As soon as possible, but no later than August 15th, 2008.

I. GENERAL INFORMATION

A. Background: Under their 9th Statement of Work (SOW), QIOs will no longer be performing the majority of utilization reviews for acute inpatient prospective payment system (IPPS) hospital and long term care hospital (LTCH) claims. They ceased selecting claims for review after December 31st, 2007. The Office of Financial Management is assuming responsibility for oversight of certain non quality-related medical review (MR) of claims, transitioning responsibility for this work to Medicare fiscal intermediaries (FIs) and Part A and B Medicare administrative contractors (A/B MACs). The QIOs will retain their responsibility for performing expedited determinations, HINN reviews, quality reviews, provider-requested higher-weighted DRG reviews, and other functions outside the scope of FI and MAC MR.

B. Policy: FIs and MACs will now perform medical review for Acute IPPS hospital and LTCH claims (which, for the purposes of this instruction, also includes claims from any hospital that would be subject to the IPPS or LTCH PPS had it not been granted a waiver), to ensure CMS only pays for covered, correctly coded, and medically necessary services. Like all other claim types, MR of these inpatient hospital claims will be based on data-analysis and conducted according to contractors' prioritized MR strategy. During the first year of the review, however, additional funding will be provided by CMS to contractors in order to ensure adequate review of these claims and reporting of findings and lessons learned. Contractors shall apply applicable coding and coverage policy, along with clinical judgment to make payment determinations and adjust claims as appropriate, as they do with all other Medicare benefits. FIs and MACs will have the authority to conduct prepayment review of these claims received beginning on the implementation of this CR and the authority to conduct postpayment review of claims submitted January 1, 2008 forward.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER PSCs/ ZPICs performing Pt A medical review
							FISS	MCS	VMS	CWF	

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER PSCs/ ZPICs performing Pt A medical review
							FISS	MCS	VMS	CWF	
5849.1	The contractor shall include acute inpatient PPS (IPPS) hospital claims data in their data analysis for development of prioritized medical review strategies.	X		X							X
5849.2	The contractor shall include long term care hospital (LTCH) claims data in their data analysis for development of prioritized medical review strategies.	X		X							X
5849.3	The contractor shall include medical review interventions, including prepayment review, postpayment review, and provider notification and feedback, for acute IPPS hospital and LTCH, as part of their prioritized strategy and strategy analysis report (SAR) after March 31, 2009, as indicated in their data analysis.	X		X							X
5849.4	From implementation date of this instruction until March 31st, 2009 only, contractors shall, at their discretion, perform random postpay review of acute IPPS and LTCH claims.	X		X							X
5849.5	From implementation date of this instruction until March 31st, 2009 only, FIs shall report costs and workload in new CAFM II activity code #17609 in CAFM II for this first phase of acute IPPS hospital and LTCH claims review.	X		X							X
5849.6	A/B MACs shall report in CMS ARTS in the line to be specified in their respective contracts.	X									
5849.7	Contractors shall submit a report containing findings from the first phase of acute IPPS hospital and LTCH review, through March 31st, 2009, no later than May 1, 2009.	X		X							X
5849.8	After March 31, 2009, contractors will report as they would report medical review for any other bill type.	X		X							X
5849.9	From implementation date of this instruction until March 31st, 2009 only, contractors may only use funds distributed in association with this instruction to perform random and non-random review of acute IPPS hospital and LTCH claims.	X		X							X

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER PSCs/ ZPICs performing Pt A medical review
							FISS	MCS	VMS	CWF	
5849.10	From information gained from review from the implementation date of this instruction until March 31st, 2009, contractors shall submit a final report on acute IPPS hospital and LTCH claims workload and findings for these reviews by May 1, 2009.	X		X							X
5949.11	The FIs shall submit this report to Kim Spalding at the address below, and MACs shall submit this report to their project officer.	X		X							X
5849.12	The contractor shall consider performing postpayment review of acute IPPS hospital and LTCH claims submitted on January 1, 2008 or later.	X		X							X
5849.13	The contractor shall utilize screening instruments, as applicable, as part of the complex review of each acute IPPS hospital and LTCH claim.	X		X							X
5849.14	The contractor shall consult with physicians and/or other experts, as necessary, during the course of complex review.	X		X							X
5849.15	The contractor shall perform medical necessity/utilization review as part of their medical review of acute IPPS hospital and LTCH claims.	X		X							X
5849.16	The contractor shall determine whether inpatient hospital admission was medically necessary, according to IOM 100-02, chapter 1, §10.	X		X							X
5849.16.1	The contractor shall pay the claim according to the appropriate DRG, in accordance with IOM 100-08, chapter 6, §6.5.4, when an inpatient level of care is determined to have been appropriate from the date of admission.	X		X							X
5849.16.2.	The contractor shall utilize the first day on which an inpatient level of care is determined to be medically necessary as the deemed date of admission when it is determined that an inpatient level of care was not medically necessary on admission, but became medically necessary at some point during the stay.	X		X							X

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER PSCs/ ZPICs performing Pt A medical review
							FISS	MCS	VMS	CWF	
5849.16.2.1	The contractor shall not include services provided prior to the deemed date of admission for the purposes of calculating outlier payments.	X		X							X
5849.16.2.2	The contractor shall pay the claim using the diagnosis determined to be chiefly responsible for the patient's need for covered services on the deemed date of admission as the principal diagnosis.	X		X							X
5849.16.3	The contractor shall deny the claim in full when they determine that care at an inpatient level was not necessary at any time during the stay.	X		X							X
5849.17	The contractor shall perform DRG validation review as part of their medical review of acute IPPS and LTCHs.	X		X							X
5849.18	The contractor shall utilize individuals trained and experienced in ICD-9 CM coding to perform DRG validation review.	X		X							X
5849.19	The contractor shall ensure consistency with ICD-9 CM coding guidelines for review of coding during DRG validation review.	X		X							X
5849.19.1	The contractor shall use the ICD-9 CM coding guidelines in place at the time that services were rendered for review of coding during DRG validation review.	X		X							X
5849.20	The contractor shall ensure consistency with Uniform Hospital Discharge Data element definitions during DRG validation review.	X		X							X
5849.21	The contractor shall ensure that the proper principal and relevant secondary diagnoses were reported on the claim as part of DRG validation review.	X		X							X
5849.22	The contractor shall insert any relevant secondary diagnoses identified through medical record review, that were not recorded on the claim form, for DRG calculation purposes.	X		X							X
5849.23	The contractor shall use the diagnosis which, after study, is determined to have occasioned the patient's admission to the hospital as the principal diagnosis for DRG calculation purposes.	X		X							X
5849.24	The contractor shall exclude any diagnoses relating to an earlier episode, that have no bearing on the current hospital stay, for DRG calculation purposes.	X		X							X

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER PSCs/ ZPICs performing Pt A medical review
							FISS	MCS	VMS	CWF	
5849.25	The contractor shall verify that all procedures affecting DRG assignment were appropriately reported, for DRG calculation purposes.	X		X							X
5849.26	The contractor shall deny a claim for which the sole purpose of admission was for a procedure determined not to have been medically necessary AND the patient never developed a need for a covered level of care.	X		X							X
5849.27	The contractor shall pay a claim for which the sole purpose of admission was NOT for a procedure subsequently determined not to have been medically necessary, according to the DRG calculated upon removal of the non-medically necessary procedure.	X		X							X
5849.28	The contractor shall exclude any days for which the patient was receiving care solely related to the performance of a procedure determined not to have been medically necessary, for the purposes of cost outlier calculation.	X		X							X
5849.29	The contractor shall make a referral to the QIO for any case in which a beneficiary received procedures which were not medically necessary.	X		X							X
5849.30	The contractor should consider including DRG 468 claims, claims with primary diagnoses representing questionable admissions, and claims with primary diagnoses that are only acceptable when billed with a secondary diagnosis in their data analysis for development of a prioritized MR strategy.	X		X							X
5849.31	The contractor shall determine whether the length of stay was appropriate for claims selected for medical review that represent PPS cost outliers.	X		X							X
5849.32	The contractor shall not include days on which care is determined not to have been medically necessary in the calculation of outlier payments	X		X							X

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER PSCs/ ZPICs performing Pt A medical review
							FISS	MCS	VMS	CWF	
5849.33	The contractor shall make a referral to the PSC/ZPIC when it is determined that a beneficiary's stay was unnecessarily long, and potentially represents fraud or abuse.	X		X							X
5849.34	The contractor shall review only Medicare-covered portions of inpatient hospital stays and as much of the stay preceding Medicare coverage as is necessary to make a payment determination.	X		X							X
5849.35	The contractor shall perform length-of-stay review for all inpatient hospital claims in PPS waived areas that are selected for medical review.	X		X							X
5849.36	The contractor shall perform medical review, as outlined in IOM 100-08, §6.5 and its subsections, then make a referral to the QIO for any claim selected for medical review that is associated with a readmission to an acute, short-term PPS hospital occurring within 31 days of discharge from the same or another acute, short-term hospital.	X		X							X
5849.37	The contractor shall perform medical review, as outlined in IOM 100-08, §6.5 and its subsections, then make a referral to the QIO for any claim selected for medical review that is associated with a transfer, as described in §6.5.6.	X		X							X
5849.38	The contractor shall make a referral to the QIO and the PSC/ZPIC for any case which it suspects represents an attempt at circumvention of PPS, as described in the Social Security Act, §1886(f)(2).	X		X							X
5849.39	Contractors shall utilize appropriate claim adjustment reason codes and remittance advice remark codes, as they do for all other claim types.	X		X							X
5849.40	Contractors shall advise beneficiaries and providers of their appeal rights on issuance of an inpatient hospital claim denial, as they do for all other claim types.	X		X							X
5849.41	PSCs and ZPICs shall coordinate with QIOs on only those acute IPPS hospital and LTCH claims with which the QIO has been involved.										X

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER PSCs/ ZPICs performing Pt A medical review
							FISS	MCS	VMS	CWF	
5849.41.1	PSC and ZPICs shall communicate with FIs and MACs on all other acute IPPS hospital and LTCH claims, as they do with all other Part A Medicare claims.										X
5849.42	FIs/MACs shall consider a review decision made by the QIO final and binding on CMS. Therefore, the issue(s) under review shall not be reviewed by the FI, MAC, PSC or ZPIC.	X		X							X
5849.43	Contractors shall recommend suspensions of inpatient hospital claims to the central office Fraud and Abuse Suspensions and Sanctions (FASS) team in the Division of Benefit Integrity Management Operations (DBIMO).	X		X							X
5849.44	Contractors shall follow instructions issued in a separate Joint Signature Memorandum regarding screening tools.	X		X							X
5849.45	Contractors shall use grouper software when adjudicating a claim.	X		X							X
5849.46	Contractors shall establish processes and procedures through joint operating agreements to ensure that the FI/MAC/PSC shall make appropriate referrals to the QIO for quality, coding, and utilization activities other than those performed by the FI/MAC/PSC/ZPIC or RAC.	X		X							X

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
5849.47	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 "MLN Matters" listserv.	X		X							

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	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 one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.										

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
5849.5	The CMS will provide more detailed instructions to contractors who report in CAFM II in the near future
5849.10	The CMS intends to issue further guidance on the content and format of this report in the near future

B. For all other recommendations and supporting information, use this space:

V. CONTACTS

Pre-Implementation Contact(s): For medical review issues: Dan Schwartz (daniel.schwartz@cms.hhs.gov), Kim Spalding (kimberly.spalding@cms.hhs.gov), Nancy Moore (nancy.moore@cms.hhs.gov). For Claims Processing Issues: Joseph Bryson (joseph.bryson@cms.hhs.gov).

Post-Implementation Contact(s): Regional offices (FIs) and project officers (MACs).

VI. FUNDING

A. *For Fiscal Intermediaries, Carriers, and the Durable Medical Equipment Regional Carrier (DMERC)*:
Additional funding will be provided by CMS through new NOBAs.

B. *For Medicare Administrative Contractors (MAC)*:

The Medicare administrative contractor (MAC) is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as changes to the MAC Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts specified 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.

Medicare Claims Processing Manual

Chapter 3 - Inpatient Hospital Billing

Table of Contents

(Rev. 1571; 08-07-08)

20 - Payment Under Prospective Payment System (PPS) Diagnosis Related Groups (DRGs)

(Rev. 1571; Issued: 08-07-08; Effective Date: 08-01-08; Implementation Date: 08-15-08)

A. General

The Social Security Amendments of 1983 (P.L. 98-21) provided for establishment of a prospective payment system (PPS) for Medicare payment of inpatient hospital services. (See §20.4 for corresponding information for PPS capital payments and computation of capital and operating outliers for FY 1992.) Under PPS, hospitals are paid a predetermined rate per discharge for inpatient hospital services furnished to Medicare beneficiaries. Each type of Medicare discharge is classified according to a list of DRGs. These amounts are, with certain exceptions, payment in full to the hospital for inpatient operating costs. Beneficiary cost-sharing is limited to statutory deductibles, coinsurance, and payment for noncovered items and services. Section 4003 of OBRA of 1990 (P.L. 101-508) expands the definition of inpatient operating costs to include certain preadmission services. (See §40.3.)

The statute excludes children's hospitals and cancer hospitals, hospitals located outside the 50 States. In addition to these categorical exclusions, the statute provides other special exclusions, such as hospitals that are covered under State reimbursement control systems. These excluded hospitals and units are paid on the basis of reasonable costs subject to the target rate of increase limits.

In accordance with Section 1814 (b) (3) of the Act, services provided by hospitals in Maryland subject to the Health Services Cost Review Commission (provider numbers 21000-21099) are paid according to the terms of the waiver, that is 94% of submitted charges subject to any unmet Part B deductible and coinsurance.

For discharges occurring on or after April 1, 1988, separate standardized payment amounts are established for large urban areas and rural areas. Large urban areas are urban areas with populations of more than 1,000,000 as determined by the Secretary of HHS on the basis of the most recent census population data. In addition, any New England County Metropolitan Area (NECMA) with a population of more than 970,000 is a large urban area.

The OBRA 1987 required payment of capital costs under PPS effective with cost reporting periods that began October 1, 1991, or later. A 10-year transition period was provided to protect hospitals that had incurred capital obligations in excess of the standardized national rate from major disruption. High capital cost hospitals are known as "hold harmless" hospitals. The transition period also provides for phase-in of the national Federal capital payment rate for hospitals with capital obligations that are less than the national rate. New hospitals that open during the transition period are exempt from capital PPS payment for their first 2 years of operation. Hospitals and hospital distinct part units that are excluded from PPS for operating costs are also excluded from

PPS for capital costs.

Capital payments are based on the same DRG designations and weights, outlier guidelines, geographic classifications, wage indexes, and disproportionate share percentages that apply to operating payments under PPS. The indirect teaching adjustment is based on the ratio of residents to average daily census. The hospital split bill, adjustment bill, waiver of liability and remaining guidelines that have historically been applied to operating payments also apply to capital payments under PPS.

B. Hospitals and Units Excluded

The following hospitals and distinct part hospital units (DPU) are excluded from PPS and are paid on a reasonable cost or other basis:

- Pediatric hospitals whose inpatients are predominately under the age of 18.

Hospitals located outside the 50 States.

- Hospitals participating in a CMS-approved demonstration project or State payment control system.

- Nonparticipating hospitals furnishing emergency services have not been affected by the PPS statute (P.L. 97-21). They are paid under their existing basis.

C. Situations Requiring Special Handling

1. Sole community hospitals are paid in accordance with the methods used to establish the operating prospective rates for the first year of the PPS transition for operating costs. The appropriate percentage of hospital-specific rate and the Federal regional rate is applied by the Pricer program in accordance with the current values for the appropriate fiscal year.

2. Hospitals have the option to continue to be reimbursed on a reasonable cost basis subject to the target ceiling rate or to be reimbursed under PPS if the following are met:

- Recognized as of April 20, 1983, by the National Cancer Institute as comprehensive cancer centers or clinical research centers;

- Demonstrating that the entire facility is organized primarily for treatment of, and research on, cancer; and

- Having a patient population that is at least 50 percent of the hospital's total discharges with a principal diagnosis of neoplastic disease.

The hospital makes this decision at the beginning of its fiscal year. The choice continues until the hospital requests a change. If it selects reasonable cost subject to the target

ceiling, it can later request PPS. No further option is allowed.

3. Regional and national referral centers within short-term acute care hospital complexes. Rural hospitals that meet the criteria have their prospective rate determined on the basis of the urban, rather than the rural, adjusted standardized amounts, as adjusted by the applicable DRG weighting factor and the hospital's area wage index.

4. Hospitals in Alaska and Hawaii have the nonlabor related portion of the wage index adjusted by their appropriate cost-of-living factor. These calculations are made by the Pricer program and are included in the Federal portion of the rate.

5. Kidney, heart, and liver acquisition costs incurred by approved transplant centers are treated as an adjustment to the hospital's payments. These payments are adjusted in each cost reporting period to compensate for the reasonable expenses of the acquisition and are not included in determining prospective payment.

6. Religious nonmedical health care institutions are paid on the basis of a predetermined fixed amount per discharge. Payment is based on the historical inpatient operating costs per discharge and is not calculated by Pricer.

7. Transferring hospitals with discharges assigned to MS-DRG 789 (neonates, died or transferred to another acute care facility) or MS-DRG 927-935 (burns - transferred to another acute care facility) have their payments calculated by the Pricer program on the same basis as those receiving the full prospective payment. They are also eligible for cost outliers.

8. Nonparticipating hospitals furnishing emergency services are not included in PPS.

9. Veterans Administration (VA) hospitals are generally excluded from participation. Where payments are made for Medicare patients, the payments are determined in accordance with 38 U.S.C. 5053(d).

10. A hospital that loses its urban area status as a result of the Executive Office of Management and Budget redesignation occurring after April 20, 1983, may qualify for special consideration by having its rural Federal rate phased-in over a 2-year period. The hospital will receive, in addition to its rural Federal rate in the first cost reporting period, two-thirds of the difference between its rural Federal rate and the urban Federal rate that would have been paid had it retained its urban status. In the second reporting period, one-third of the difference is applied. The adjustment is applied for two successive cost reporting periods beginning with the cost-reporting period in which CMS recognizes the reclassification.

11. The payment per discharge under the PPS for hospitals in Puerto Rico is the sum of:

- 50 percent of the Puerto Rico discharge weighted urban or rural standardized rate.

- 50 percent of the national discharge weighted standardized rate.

(The special treatment of referral centers and sole community hospitals does not apply to prospective payment hospitals in Puerto Rico.)

There are special criteria that facilities must meet in order to obtain approval for payment for heart transplants and special processing procedures for these bills. (See §90.2.) Facilities that wish to obtain coverage of heart transplants for their Medicare patients must submit an application and documentation showing their initial and ongoing compliance with the criteria. For facilities that are approved, Medicare covers under Part A all medically reasonable and necessary inpatient services.

12. Hospitals with high percentage of ESRD discharges may qualify for additional payment. These payments are handled as adjustments to cost reports.

13. Exception payments are provided for hospitals with inordinately high levels of capital obligations. They will expire at the end of the 10-year transition period. Exception payments ensure that for FY 1992 and FY 1993:

- Sole community hospitals receive 90 percent of Medicare inpatient capital costs:

- Urban hospitals with 100 or more beds and a disproportionate share patient percentage of at least 20.2 percent receive 80 percent of their Medicare inpatient capital costs; and

- All other hospitals receive 70 percent of their Medicare inpatient capital costs.

A limited capital exception payment is also provided during the 10-year capital transition period for hospitals that experience extraordinary circumstances that require an unanticipated major capital expenditure. Events such as a tornado, earthquake, catastrophic fire, or a hurricane are examples of extraordinary circumstances. The capital project must cost at least $5 million to qualify for this exception.

D. MS-DRG Classification

The MS-DRGs (Medicare Severity DRGs) are a patient classification system which provides a means of relating types of patients a hospital treats (i.e., its case mix) to the costs incurred by the hospital. Payment for inpatient hospital services is made on the basis of a rate per discharge that varies according to the MS-DRG to which a beneficiary's stay is assigned. All inpatient transfer/discharge bills from both PPS and non-PPS facilities, including those from waiver States, long-term care facilities, and excluded units are classified by the Grouper software program into one of *745* diagnosis related groups (DRGs).

The following MS-DRGs receive special attention:

- **MS-DRGs No. 981-983** - Represent discharges with valid data, but the surgical procedure is unrelated to the principal diagnosis. MS-DRGs 981 (Extensive O.R. Procedure Unrelated to the Principal Diagnosis w/ MCC), 982 (Extensive O.R. Procedure Unrelated to the Principal Diagnosis w/ CC), and 983 (Extensive O.R. Procedure Unrelated to the Principal Diagnosis w/o CC/MCC) each have relative weights assigned to them and will be paid. The hospital must review the record on each of these MS-DRGs in the remittance record and determine that where either the principle diagnosis or surgical procedure was reported incorrectly, prepare an adjustment bill. The FI may elect to avoid the adjustment bill by returning the bill to the hospital prior to payment.

- **MS-DRG No. 998** - Represents a discharge reporting a principle diagnosis that is invalid as a principal diagnosis. Examples include a diagnosis of diabetes mellitus or an infection of the genitourinary tract during pregnancy, both unspecified as to episode of care. These diagnoses may be valid, but they are not sufficient to determine the principal diagnosis for MS-DRG assignment purposes. FIs will return the claims. The hospital must enter the corrected principal diagnosis for proper MS-DRG assignment and resubmit the claim.

- **MS-DRG No. 999** - Represents a discharge with invalid data, making it ungroupable. FIs return the claims for correction of data elements affecting proper MS-DRG assignment. The hospital resubmits the corrected claim.

When the bills are processed in conjunction with the MCE (see §20.2.1) coding inconsistencies in the information and data are identified.

The MCE must be run before Grouper to identify inconsistencies before the bills are processed through the Grouper.

E. Difference in Age/Admission Versus Discharge
HO-415.4

When a beneficiary's age changes between the date of admission and date of discharge, the DRG and related payment amount are determined from the patient's age at admission.

20.1.2 - Outliers

(Rev. 1571; Issued: 08-07-08; Effective Date: 08-01-08; Implementation Date: 08-15-08)

Section 1886(d)(5)(A) of the Act provides for Medicare payments to Medicare-participating hospitals in addition to the basic prospective payments for cases incurring extraordinarily high costs. This additional payment known as an “Outlier” is designed to protect the hospital from large financial losses due to unusually expensive cases. To qualify for outlier payments, a case must have costs above a fixed-loss cost threshold amount (a dollar amount by which the costs of a case must exceed payments in order to qualify for outliers), which is published in the annual Inpatient Prospective Payment

System final rule. The regulations governing payments for operating costs under the IPPS are located in 42 CFR Part 412. The specific regulations governing payments for outlier cases are located at 42 CFR 412.80 through 412.86.

The actual determination of whether a case qualifies for outlier payments is made by the fiscal intermediary (FI) or A/B Medicare Administrative Contractor (MAC) using Pricer, which takes into account both operating and capital costs and diagnostic related group (DRG) payments. That is, the combined operating and capital costs of a case must exceed the fixed loss outlier threshold to qualify for an outlier payment. The operating and capital costs are computed separately by multiplying the total covered charges by the operating and capital cost-to-charge ratios. The estimated operating and capital costs are compared with the fixed-loss threshold after dividing that threshold into an operating portion and a capital portion (by first summing the operating and capital ratios and then determining the proportion of that total comprised by the operating and capital ratios and applying these percentages to the fixed-loss threshold). The thresholds are also adjusted by the area wage index (and capital geographic adjustment factor) before being compared to the operating and capital costs of the case. Finally, the outlier payment is based on a marginal cost factor equal to 80 percent of the combined operating and capital costs in excess of the fixed-loss threshold (90 percent for burn DRGs). Any outlier payment due is added to the DRG adjusted base payment rate, plus any DSH, IME and new technology add-on payment. For a more detailed explanation on the calculation of outlier payments, visit our Web site at http://www.cms.hhs.gov/providers/hipps/ippsotlr.asp .

The A/B MACs or the FI may choose to review outliers if data analysis deems it a priority.

The IPPS outliers are not applicable to non-PPS hospitals. The Pricer program makes all outlier determinations except for the medical review determination. Outlier payments apply only to the Federal portion of a capital PPS payment.

20.1.2.9 - *Medical* Review and Adjustments

(Rev. 1571; Issued: 08-07-08; Effective Date: 08-01-08; Implementation Date: 08-15-08)

Effective April 1, 2008, QIOs are no longer performing the majority of medical review for payment of acute inpatient prospective payment system (IPPS) hospital and long term care hospital (LTCH) claims. These reviews are the responsibility of the A/B MACs or the FIs. An exception occurs when a provider requests a higher-weighted DRG review from the QIO. The QIO will continue to perform those reviews.

The *A/B MAC or the FI may* review a sample of cost outlier cases after payment. The charges for any services identified as non-covered through this review are denied and any outlier payment made for these services is recovered, as appropriate, after a determination as to the provider's liability has been made.

If the *A/B MAC or the FI* finds a pattern of inappropriate utilization by a hospital, all cost outlier cases from that hospital *may be* subject to medical review, and this review may be conducted prior to payment until the *A/B MAC or the FI* determines that appropriate corrective actions have been taken.

When the *A/B MAC or the FI* reviews cost outlier cases, *they shall do so* using the medical records and itemized charges, to verify the following:

1. The admission was medically necessary and appropriate;

2. Services were medically necessary and delivered in the most appropriate setting;

3. Services were ordered by the physician, actually furnished, and not duplicatively billed; and

4. The diagnostic and procedural *coding* are correct.

Where the *A/B MAC's or the FI's* decision changes previously processed bills, an adjustment bill is prepared to correct the bill.

When the hospital provides the *A/B MACs or the FIs* with medical records for cost outlier review, the hospital must indicate the precise revenue code for each charge billed. In case adjustments are needed, revenue codes are necessary to ensure proper accounting for cost report purposes. It is not acceptable for the hospital to merely provide listings of revenue codes expecting the *A/B MACs or the FIs* to assign the charges to the appropriate code. If the correct revenue codes are not provided, the *A/B MACs or the FIs* will deny the bill.

20.2 - Computer Programs Used to Support Prospective Payment System

(Rev. 1571; Issued: 08-07-08; Effective Date: 08-01-08; Implementation Date: 08-15-08)

Medicare Code Editor

The Medicare Code Editor (MCE) is a front-end software program that edits claims to detect incorrect billing data. The MCE addresses three basic types of edits which will support the DRG assignment. They include correct ICD-9-CM coding, coverage, and clinical edits.

Built into the *MCE, which is the first portion of* the Grouper program, are edits which reject incomplete or impossible codes. Claims submitted with valid diagnoses and valid diagnoses-surgical procedure combinations but are incorrect in that they do not represent the actual diagnosis or procedure, cannot be detected. The responsibility for accuracy rests with the hospital. However, a post claim approval review *may be* conducted by the *A/B MACs or the FIs,* using medical records and the approved claim.

Grouper Program

The Grouper program determines the DRG from data elements the hospital reported. It is used on all inpatient discharge/transfer bills received from both PPS and non-PPS facilities, including those from waiver States, long-term care hospitals, and excluded units.

Pricer Program

The Pricer program determines the amount to pay under prospective payment.

The Pricer program applies the DRG relative weights, hospital urban or rural and census division location, hospital specific data, and beneficiary hospital data from the bill to determine the amount payable for each PPS discharge bill.

Most hospitals should not need a Pricer program because only one rate per DRG applies unless the claim results in a cost outlier for a beneficiary who's benefits are exhausted during the stay. For those claims, the provider must identify the outlier threshold to properly bill covered days on an inpatient claim. See §20.7.4 below. Hospitals and hospital claims in multiple geographic areas may obtain a Pricer from

National Technical Institute
U.S. Department of Commerce
NTIS
Springfield, VA 22161.

Hospitals may also download a PC Pricer that will process one record at the time from the CMS Web site at: http://www.cms.hhs.gov/providers/pricer/default.asp.

20.2.1 - Medicare Code Editor (MCE)

(Rev. 1571; Issued: 08-07-08; Effective Date: 08-01-08; Implementation Date: 08-15-08)

A. General

The MCE edits claims to detect incorrect billing data. In determining the appropriate DRG for a Medicare patient, the age, sex, discharge status, principal diagnosis, secondary diagnosis, and procedures performed must be reported accurately to the Grouper program. The logic of the Grouper software assumes that this information is accurate and the Grouper does not make any attempt to edit the data for accuracy. Only where extreme inconsistencies occur in the patient information will a patient not be assigned to a DRG. Therefore, the MCE is used to improve the quality of information given to Grouper.

The MCE addresses three basic types of edits which will support the DRG assignment:

Code Edits - Examines a record for the correct use of ICD-9-CM codes that describe a patient's diagnoses and procedures. They include basic consistency checks on the interrelationship among a patient's age, sex, and diagnoses and procedures.

Coverage Edits - Examines the type of patient and procedures performed to determine if the services where covered.

Clinical Edits - Examines the clinical consistency of the diagnostic and procedural information on the medical claim to determine if they are clinically reasonable and, therefore, should be paid.

B. Implementation Requirements

The FI processes all inpatient Part A discharge/transfer bills for both PPS and non-PPS facilities (including waiver States, long-term care hospitals, and excluded units) through the MCE. It processes claims that have been reviewed by the QIO prior to billing through the MCE only for edit types 1, 2, 3, 4, 7, and 12. It does not process the following kinds of bills through the MCE:

- Where no Medicare payment is due (amounts reported by value codes 12, 13, 14, 15, or 16 equal or exceed charges).

- Where no Medicare payment is being made. Where partial payment is made, editing is required.

- Where QIO reviewed prior to billing (code C1 or C3 in FL 24-30). It may process these exceptions through the program and ignore development codes or bypass the program.

The MCE software contains multiple versions. The version of the MCE accessed by the program depends upon the patient discharge date entered on the claim.

C. Bill System/MCE Interface

The FI installs the MCE online, if possible, so that prepayment edit requirements identified in subsection C can be directed to hospitals without clerical handling.
The MCE needs the following data elements to analyze the bill:

- Age;

- Sex;

- Discharge status;

- Diagnosis (9 maximum – principal diagnosis and up to 8 additional diagnoses);
- Procedures (6 maximum); and
- Discharge date.

The MCE provides the FI an analysis of "errors" on the bill as described in subsection D. The FI develops its own interface program to provide data to MCE and receive data from it.

The MCE Installation Manual describes the installation and operation of the program, including data base formats and locations.

D. Processing Requirements

The hospital must follow the procedure described below for each error code. For bills returned to the provider, the FI considers the bill improperly completed for control and processing time purposes. (See chapter 1.)

1. Invalid Diagnosis or Procedure Code

The MCE checks each diagnosis code, including the admitting diagnosis, and each procedure code against a table of valid ICD-9-CM codes. An admitting diagnosis, a principle diagnosis, and up to eight additional diagnoses may be reported. Up to six total procedure codes may be reported on an inpatient claim. If the recorded code is not in this table, the code is invalid, and the FI returns the bill to the provider.

For a list of all valid ICD-9-CM codes see "International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), January 1979, Volume I (Diseases)" and "Volume 3 (Procedures)," and the "Addendum/Errata" and new codes furnished by the FI. The hospital must review the medical record and/or face sheet and enter the correct diagnosis/procedure codes before returning the bill.

2. Invalid Fourth or Fifth Digit

The MCE identifies any diagnosis code, including the admitting diagnosis or any procedure that requires a fourth or fifth digit, which is either missing or not valid for the code in question.

For a list of all valid fourth and fifth digit ICD-9-CM codes see "International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), January 1979, Volume 1 (Diseases)" and "Volume 3 (Procedures)," and the "Addendum/Errata" and new codes furnished by the FI. The FI returns claims edited for this reason to the hospital. The hospital must review the medical record and/or face sheet and enter the correct diagnosis/procedure before returning the bill.

3. E-Code as Principal Diagnosis

E-codes describe the circumstances that caused an injury, not the nature of the injury, and therefore are not recognized by the Grouper program as acceptable principal diagnoses. E-codes are all ICD-9-CM diagnosis codes that begin with the letter E. For a list of all E-codes, see "International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), January 1979, Volume l (Diseases)." The hospital must review the medical record and/or face sheet and enter the correct diagnosis before returning the bill.

4. Duplicate of PDX

Any secondary diagnosis that is the same code as the principal diagnosis is identified as a duplicate of the principal diagnoses. This is unacceptable because the secondary diagnosis may cause an erroneous assignment to a higher severity MS-DRG. Hospitals may not repeat a diagnosis code. The FI will delete the duplicate secondary diagnosis and process the bill.

5. Age Conflict

The MCE detects inconsistencies between a patient's age and any diagnosis on the patient's record. Examples are:

- A 5-year-old patient with benign prostatic hypertrophy.
- A 78-year-old delivery.

In the above cases, the diagnosis is clinically impossible in a patient of the stated age. Therefore, either the diagnosis or age is presumed to be incorrect. Four age code categories are described below.

- A subset of diagnoses is intended only for newborns and neonates. These are "Newborn" diagnoses. For "Newborn" diagnoses, the patient's age must be 0 years.
- Certain diagnoses are considered reasonable only for children between the ages of 0 and 17. These are "Pediatric" diagnoses.
- Diagnoses identified as "Maternity" are coded only for patients between the ages of l2 and 55 years.
- A subset of diagnoses is considered valid only for patients over the age of 14. These are "Adult" diagnoses. For "Adult" diagnoses the age range is 15 through 124.

The diagnoses described in the Medicare Code Editor, posted on the CMS webpage at: http://www.cms.hhs.gov/AcuteInpatientPPS/FFD/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=2&sortOrder=ascending&itemID=CMS1206058&intNumPerPage=10

are acceptable only for the age categories shown. If the FI edits online, it will return such bills for a proper diagnosis or correction of age as applicable. If the FI edits in batch operations after receipt of the admission query response, it uses the age based on CMS records and returns bills that fail this edit. The hospital must review the medical record and/or face sheet and enter the proper diagnosis or patient's age before returning the bill.

6. Sex Conflict

The MCE detects inconsistencies between a patient's sex and a diagnosis or procedure on the patient's record. Examples are:

- Male patient with cervical cancer (diagnosis).
- Male patient with a hysterectomy (procedure).

In both instances, the indicated diagnosis or the procedure conflicts with the stated sex of the patient. Therefore, either the patient's diagnosis, procedure or sex is incorrect.

The Medicare Code Editor contains listings of male and female related ICD-9-CM diagnosis and procedure codes and the corresponding English descriptions. The hospital should review the medical record and/or face sheet and enter the proper sex, diagnosis, and procedure before returning the bill.

7. Manifestation Code As Principal Diagnosis

A manifestation code describes the manifestation of an underlying disease, not the disease itself, and therefore, cannot be a principal diagnosis. *The Medicare Code Editor* contains listings of ICD-9-CM diagnoses identified as manifestation codes. The hospital should review the medical record and/or face sheet and enter the proper diagnosis before returning the bill.

8. Nonspecific Principal Diagnosis

Effective October 1, 2007 (FY 2008), the non-specific principal diagnosis edit was discontinued and will appear for claims processed using MCE version 2.0-23.0 only.

9. Questionable Admission

There are some diagnoses which are not usually sufficient justification for admission to an acute care hospital. For example, if a patient is given a principal diagnosis of:

4011 - Benign Hypertension

then this patient would have a questionable admission, since benign hypertension is not normally sufficient justification for admission.

The Medicare Code Editor contains a listing of ICD-9-CM diagnosis codes identified as "Questionable Admission" when used as principal diagnosis.

The A/B MACs or the FIs may review on a post-payment basis all questionable admission cases. Where the *A/B MACs or the FIs* determines the denial rate is sufficiently high to warrant, *it may review the claim before payment*.

10. Unacceptable Principal Diagnosis

There are selected codes that describe a circumstance which influences an individual's health status but is not a current illness or injury; therefore, they are unacceptable as a principal diagnosis. For example, Vl73 (Family History of Ischemic Heart Disease) is an unacceptable principal diagnosis.

In a few cases, there are codes that are acceptable if a secondary diagnosis is coded. If no secondary diagnosis is present for them, MCE returns the message "requires secondary dx." The *A/B MAC or the FI may* review claims with diagnosis V571, V5721, V5722, V573, V5789, and V579 and a secondary diagnosis. *A/B MACs or FIs may choose to review as a principal diagnosis if data analysis deems it a priority.*

If these codes are identified without a secondary diagnosis, the FI returns the bill to the hospital and requests a secondary diagnosis that describes the origin of the impairment. Also, bills containing other "unacceptable principal diagnosis" codes are returned.

The hospital reviews the medical record and/or face sheet and enters the principal diagnosis that describes the illness or injury before returning the bill.

11. Nonspecific O.R. Procedures

Effective October 1, 2007 (FY 2008), the non-specific O.R. procedure edit was discontinued and will appear for claims processed using MCE version 2.0-23.0 only.

12. Noncovered O.R. Procedures

There are some O.R. procedures for which Medicare does not provide payment. The FI will return the bill requesting either:

- A no pay bill, or
- A correction in the procedure code.
- A bill indicating the covered and noncovered procedures.

If the hospital indicates that there are covered and noncovered procedures, the FI refers the bill to the QIO for prepayment review. Upon receipt of the QIOs response, it either deletes the noncovered procedures and charges or requires the hospital to delete them. It

does not process the noncovered procedures through Grouper or the noncovered charges through Pricer.

13. Open Biopsy Check

Biopsies can be performed as open (i.e., a body cavity is entered surgically), percutaneously, or endoscopically. The DRG Grouper logic assign a patient to different DRGs depending upon whether or not the biopsy was open. In general, for most organ systems, open biopsies are performed infrequently.

Effective October 1, 1987, there are revised biopsy codes that distinguish between open and closed biopsies. To make sure that hospitals are using ICD-9-CM codes correctly, the FI requests O.R. reports on a sample of 10 percent of claims with open biopsy procedures for review on a post payment basis.

If the O.R. report reveals that the biopsy was closed (performed percutaneously, endoscopically, etc.) the FI changes the procedure code on the bill to the closed biopsy code and processes an adjustment bill. Some biopsy codes (3328 and 5634) have two related closed biopsy codes, one for closed endoscopic and for closed percutaneous biopsies. The FI assigns the appropriate closed biopsy code after reviewing the medical information.

14. Medicare as Secondary Payer - MSP Alert

The MCE identifies situations that may involve automobile medical, no-fault or liability insurance. The hospital must develop other insurance coverage as provided in the Medicare Secondary Payer Manuals, before billing Medicare.

15. Bilateral Procedure

There are codes that do not accurately reflect performed procedures in one admission on two or more different bilateral joints of the lower extremities. A combination of these codes show a bilateral procedure when, in fact, they could be single joint procedures (i.e., duplicate procedures).

If two more of these procedures are coded, and the principal diagnosis is in MDC 8, the claim is flagged for post-pay development. The FI processes the bill as coded but requests an O.R. report. If the report substantiates bilateral surgery, no further action is necessary. If the O.R. report does not substantiate bilateral surgery, an adjustment bill is processed.

If the error rate for any provider is sufficiently high, the FI may develop claims prior to payment on a provider-specific basis.

16. Invalid Age

If the hospital reports an age over l24, the FI requests the hospital to determine if it made a bill preparation error. If the beneficiary's age is established at over l24, the hospital enters 123.

17. Invalid Sex

A patient's sex is sometimes necessary for appropriate DRG determination. Usually the FI can resolve the issue without hospital assistance. The sex code reported must be either 1 (male) or 2 (female).

18. Invalid Discharge Status

A patient's discharge status is sometimes necessary for appropriate DRG determination. Discharge status must be coded according to the Form CMS-1450 conventions. See Chapter 25.

19. Invalid Discharge Date

An invalid discharge date is a discharge date that does not fall into the acceptable range of numbers to represent, either the month, day or year (e.g., 13/03/01, 12/32/01). If no discharge date is entered, it is also invalid. MCE reports when an invalid discharge date is entered.

40.2.5 - Repeat Admissions

(Rev. 1571; Issued: 08-07-08; Effective Date: 08-01-08; Implementation Date: 08-15-08)

A patient who requires follow-up care or elective surgery may be discharged and readmitted or may be placed on a leave of absence.

Hospitals may place a patient on a leave of absence when readmission is expected and the patient does not require a hospital level of care during the interim period. Examples could include, but are not limited to, situations where surgery could not be scheduled immediately, a specific surgical team was not available, bilateral surgery was planned, or when further treatment is indicated following diagnostic tests but cannot begin immediately. Institutional providers may not use the leave of absence billing procedure when the second admission is unexpected.

The A/B MACs or FIs may choose to review claims if data analysis deems it a priority. AB/MACs FIs will review the claim selected, based on the medical record associated with that claim and make a payment determination on that claim. They will then refer the claim to the QIO, in accordance with IOM 100-08, chapter 6, §6.5.7.

The QIOs may review acute care hospital admissions occurring within 30 days of discharge from an acute care hospital if both hospitals are in the *QIO's jurisdiction* and if

it appears that the two confinements could be related. Two separate payments would be made for these cases unless the *readmission or preceding admission is denied.*

NOTE: *The QIO's authority to* review *and to deny* readmissions *when appropriate* is **not** limited to readmissions within 30 days. The *QIO* has the authority to deny the second admission to the same *or another acute PPS* hospital, no matter how many days elapsed since the patient's discharge.

Placing a patient on a leave of absence will not generate two payments. Only one bill and one DRG payment is made. The *A/B MAC or the FI* do not consider leave of absence bills as two admissions. It may select such bills for review for other reasons.

When a patient is discharged/transferred from an acute care Prospective Payment System (PPS) hospital, and is readmitted to the same acute care PPS hospital on the same day for symptoms related to, or for evaluation and management of, the prior stay's medical condition, hospitals shall adjust the original claim generated by the original stay by combining the original and subsequent stay onto a single claim.

Services rendered by other entities during a combined stay must be paid by the acute care PPS hospital. The acute care PPS hospital is responsible for the other entity's services per common Medicare practice.

NOTE: Medicare does not reimburse other entities for services performed during two inpatient acute care PPS stays that are combined onto a single claim. However, the other entity's services may be considered and billed as covered services, when appropriate, by the acute care PPS hospital.

When a patient is discharged/transferred from an acute care PPS hospital and is readmitted to the same acute care PPS hospital on the same day for symptoms unrelated to, and/or not for evaluation and management of, the prior stay's medical condition, hospitals shall place condition code (CC) B4 on the claim that contains an admission date equal to the prior admissions discharge date.

Upon the request of a *A/B MACs or the FIs*, hospitals must submit medical records pertaining to the readmission.

For Non-PPS acute care hospitals, such as Maryland waiver hospitals, the readmission bill (if related to original admission) does not have to be combined with the original bill if the stay spans a month. However, the original bill would have to be adjusted to change the patient status code to a 30 (still a patient). Subsequent monthly bills for this admission would be billed as interim bills, 112, 113 or 114.

50 - Adjustment Bills

(Rev. 1571; Issued: 08-07-08; Effective Date: 08-01-08; Implementation Date: 08-15-08)

Adjustment bills are the most common mechanism for changing a previously accepted bill. They are required to reflect the results of *A/B MACs or the FIs* medical review. Adjustments may also be requested by CMS via CWF if it discovers that bills have been accepted and posted in error other than the omission of a charge. Adjustments may be

initiated as a result of OIG and MSP requests. The FI will ask the provider to submit an adjustment request for certain situations.

For hard copy Form CMS-1450 adjustment requests, the provider places the ICN/DCN of the original bill for Payer A, B, or C.

Where payment is handled through the cost reporting and settlement processes, the provider accumulates a log for those items not requiring an adjustment bill. For cost settlement, the FI pays on the basis of the log. This log must include:

- Patient name;
- HICN;
- Dates of admission and discharge, or from and thru dates;
- Adjustment in charges (broken out by ancillary or routine service); and
- Any unique numbering or filing code necessary for the hospital to associate the adjustment charge with the original billing.

Providers in Maryland, which are not paid under PPS or cost reports, submit an adjustment bill for inpatient care of $500 or more, and keep a log as described above for lesser amounts. Because there are no adjustment bills, the FI enters the payment amounts from the summary log into the PPS waiver simulation and annually pays the items on the log after the cost report is filed.

NOTE: Information regarding the claim form locators that correspond with these fields and a table to crosswalk the CMS-1450 form locators to the 837 transaction is found in chapter 25.

An original bill does not have to be accepted by CMS prior to making related adjustments to the provider. However, for all adjustments other than QIO adjustments (e.g., provider submitted and/or those the FI initiates), the FI submits an adjustment bill to CWF following it's acceptance of the initial bill. To verify CMS' acceptance, it take ones or both of the following actions:

A. General Rules for Submitting Adjustment Requests

Adjustment requests that only recoup or cancel a prior payment are "credits" and must match the original in the following fields:

- intermediary control number (ICN/DCN);
- Surname;

- HICN;

When a definite match cannot be made on the 3 fields above, the provider's FI will use the fields below as needed. Note that for older claims, ICN/DCN probably will not match.

- Date of birth;

- Admission date (Start of Care Date for Home Health), unless changed by this adjustment requests; and

- From/thru dates (Date of First Visit/Date of Last Visit for Home Health), unless changed by this adjustment request.

Cancel-only adjustment requests must be submitted only in cases of incorrect provider identification numbers and incorrect HICNs. After the cancel-only request for the incorrect bill is resolved, the provider must submit correct information as a new bill.

The provider must submit all other adjustment requests as debits only. It shows the ICN/DCN of the bill to be adjusted as described above, with the bill type shown as XX7. It submits adjustment requests to its FI either electronically or on hard copy. Electronic submission is preferred.

The FI must enter the following bill types that relate to the entity generating the adjustment request:

XX7	Provider (debit)
XX8	Provider (cancel)
XXF	Beneficiary
XXG	CWF
XXH	CMS
XXI	FI
XXM	MSP
XXP	QIO/QIO
XXJ	Other
XXK	OIG

The provider submits adjustment requests as bill type XX7 or XX8. Since several different sources can initiate an adjustment for MSP purposes, the FI will change the bill type to XXM, which takes priority over any other source of an adjustment except OIG. These priorities refer only to the designation of the source of the adjustment. The difference between CWF generating the adjustment request and CMS generating the request is:

An adjustment is CWF-generated if the FI receives a CWF alert or an CMS-L1002.

The FI prepares an adjustment if instructed by CO or RO to make a change. Typically, the FI receives such direction from CMS when it decides to retroactively change payment for a class or other group of bills. Occasionally, CMS will discover an error in the processing of a single bill and direct the FI to correct it.

If the FI furnished the Part B carrier a copy of the original bill which is being adjusted, it must furnish them a copy of the adjusted bill.

If adjustment bills are rejected by CWF for additional corrections, they need to be corrected and resubmitted. Even if the adjustment action is requested by letter from CMS, the FI must submit the adjustment bill in its CWF record. If a rejected adjustment bill is determined to be unnecessary, the FI stops the adjustment action upon receipt of correction.

Where an adjustment bill changes subsequent utilization, the FI notes this and processes adjustments to subsequent bills if it services the provider.

If the FI does not service the provider, CMS will contact the FIs, which submitted bills with subsequent billing dates that are affected by the adjustments via an SSA-L389 or SSA-L1001 upon receipt of the adjusted bills in CWF. (An indicator is set by CMS on its records upon advising an FI of the appropriate adjustment actions.)

B. Adjustment Bills Involving Time Limitation for Filing Claims

If a provider fails to include a particular item or service on its initial bill, an adjustment bill(s) to include such an item(s) or service(s) is not permitted after the expiration of the time limitation for filing a claim. However, to the extent that an adjustment bill otherwise corrects or supplements information previously submitted on a timely claim about specified services or items furnished to a specified individual, it is subject to the rules governing administrative finality, rather than the time limitation for filing.

Under prospective payment, adjustment requests are required from the hospital where errors occur in diagnoses and procedure coding that change the DRG, or where the deductible or utilization is affected. A hospital is allowed 60 days from the date of the FI payment notice for adjustment bills where diagnostic or procedure coding was in error. Adjustments reported by the QIO have no corresponding time limit and are adjusted automatically by the FI without requiring the hospital to submit an adjustment bill. However, if diagnostic and procedure coding errors have no effect on the DRG, adjustment bills are not required.

Under PPS, for long-stay cases, hospitals may bill 60 days after an admission and every 60 days thereafter if they choose. The FI processes the initial bill through Grouper and Pricer. The provider must submit an adjustment to cancel the original interim bill(s) and rebill the stay from the admission date through the discharge date. When the adjustment bill is received, it processes it as an adjustment. In this case, the 60-day requirement for correction does not apply.

Where payment is handled through cost reporting and settlement processes, the provider accumulates a log for those items not requiring an adjustment bill. Maryland inpatient hospital providers also keep a log of late charges when the amount is under $500. They submit the log with their cost reports. After cost reports are filed, the FI makes a lump sum payment to cover these charges as shown on the summary log. The provider uses the summary log for late charges only under cost settlement (outpatient hospital), except in Maryland.

Maryland and cost providers are required to meet the 27-month timeframe for timely filing of claims, including late charges.

NOTE: Providers in Maryland which are not paid under PPS or cost reports, submit an adjustment bill for inpatient care of $500 or more, and submit a log for the lesser amounts.

.

90 - Billing Transplant Services

(Rev. 1571; Issued: 08-07-08; Effective Date: 08-01-08; Implementation Date: 08-15-08)

Medicare covers the following organ transplants: kidney, heart, lung, heart/lung, liver, pancreas, pancreas/kidney, and intestinal/multi-visceral. Medicare also covers stem cell transplants for certain conditions.

On March 30, 2007, the Department of Health and Human Services (DHHS) established a regulation authorizing the survey and certification of organ transplant programs. The Centers for Medicare & Medicaid Services (CMS) is the Federal agency responsible for monitoring compliance with the Medicare conditions of participation. All hospital transplant programs covered by the regulation (does not include stem cell transplants), whether currently approved by CMS or seeking initial approval, must submit a request for approval under the new regulations to CMS by December 26, 2007 (180 days from the effective date of the regulation.)

http://www.cms.hhs.gov/CertificationandComplianc/20_Transplant.asp#TopOfPage

Transplant hospitals should review the above Web site and send applications to the following address:

Centers for Medicare and Medicaid Services
Survey and Certification Group
7500 Security Blvd.
Mailstop: S2-12-25
Baltimore, MD 21244

The A/B MACs or the FI may choose to review claims if data analysis deems it a priority.

90.3 - Stem Cell Transplantation

(Rev. 1571; Issued: 08-07-08; Effective Date: 08-01-08; Implementation Date: 08-15-08)

Stem cell transplantation is a process in which stem cells are harvested from either a patient's or donor's bone marrow or peripheral blood for intravenous infusion. Autologous stem cell transplants (AuSCT) must be used to effect hematopoietic reconstitution following severely myelotoxic doses of chemotherapy (HDCT) and/or radiotherapy used to treat various malignancies. Allogeneic stem cell transplant may also be used to restore function in recipients having an inherited or acquired deficiency or defect.

Bone marrow and peripheral blood stem cell transplantation is a process which includes mobilization, harvesting, and transplant of bone marrow or peripheral blood stem cells and the administration of high dose chemotherapy or radiotherapy prior to the actual

transplant. When bone marrow or peripheral blood stem cell transplantation is covered, all necessary steps are included in coverage. When bone marrow or peripheral blood stem cell transplantation is non-covered, none of the steps are covered.

Allogeneic and autologous stem cell transplants are covered under Medicare for specific diagnoses. Effective October 1, 1990, these cases were assigned to MS-DRG 009, Bone Marrow Transplant.

The FI's Medicare Code Editor (MCE) will edit stem cell transplant procedure codes 4101, 4102, 4103, 4104, 4105, 4107, 4108, and 4109 against diagnosis codes to determine which cases meet specified coverage criteria. Cases with a diagnosis code for a covered condition will pass (as covered) the MCE noncovered procedure edit. When a stem cell transplant case is selected for review based on the random selection of beneficiaries, the QIO will review the case on a post-payment basis to assure proper coverage decisions

Procedure code 41.00 (bone marrow transplant, not otherwise specified) will be classified as noncovered and the claim will be returned to the hospital for a more specific procedure code.

The A/B MACs or the FI may choose to review if data analysis deems it a priority.

90.4.2 - Billing for Liver Transplant and Acquisition Services

(Rev. 1571; Issued: 08-07-08; Effective Date: 08-01-08; Implementation Date: 08-15-08)

Form CMS-1450 or its electronic equivalent is completed in accordance with instructions in chapter 25 for the beneficiary who receives a covered liver transplant. Applicable standard liver acquisition charges are identified separately in FL 42 by revenue code 0817 (Donor-Liver). Where interim bills are submitted, the standard acquisition charge appears on the billing form for the period during which the transplant took place. This charge is in addition to the hospital's charge for services furnished directly to the Medicare recipient.

The contractor deducts liver acquisition charges for IPPS hospitals prior to processing through Pricer. Costs of liver acquisition incurred by approved liver transplant facilities are **not** included in prospective payment DRG 480 (Liver Transplant). They are paid on a reasonable cost basis. This item is a "pass-through" cost for which interim payments are made. (See the Provider Reimbursement Manual, Part 1, §2802 B.8.) The contractor includes liver acquisition charges under revenue code 0817 in the HUIP record that it sends to CWF and the QIO.

A. Bill Review Procedures

The contractor takes the following actions to process liver transplant bills.

1. Operative Report

The contractor requires the operative report with all claims for liver transplants, or sends a development request to the hospital for each liver transplant with a diagnosis code for a covered condition.

2. MCE Interface

Code 50.51 (Auxiliary liver transplant) is always a non-covered procedure. However, the MCE contains a limited coverage edit for procedure code 50.59 (liver transplant). Where procedure code 50.59 is identified by the MCE, the contractor shall check the provider number and effective date to determine if the provider is an approved liver transplant facility at the time of the transplant, and the contractor shall also determine if the facility is certified for adults and/or pediatric transplants dependent upon the patient's age. If yes, the claim is suspended for review of the operative report to determine whether the beneficiary has at least one of the covered conditions when the diagnosis code is for a covered condition. If payment is appropriate (i.e., the facility is approved, the service is furnished on or after the approval date, and the beneficiary has a covered condition), the contractor sends the claim to Grouper and Pricer.

If none of the diagnoses codes are for a covered condition, or if the provider is not an approved liver transplant facility, the contractor denies the claim.

NOTE: Some non-covered conditions are included in the covered diagnostic codes. (The diagnostic codes are broader than the covered conditions. For example, primary biliary cirrhosis is a covered condition, secondary biliary cirrhosis is not a covered condition. Both primary and secondary biliary cirrhosis have the same **diagnosis** code ICD 9 571.6) Do not pay for noncovered conditions.

3. Grouper

If the bill shows a discharge date before March 8, 1990, the liver transplant procedure is not covered. If the discharge date is March 8, 1990 or later, the contractor processes the bill through Grouper and Pricer. If the discharge date is after March 7, 1990, and before October 1, 1990, Grouper assigned CMS DRG 191 or 192. The contractor sent the bill to Pricer with review code 08. Pricer would then overlay CMS DRG 191 or 192 with CMS DRG 480 and the weights and thresholds for CMS DRG 480 to price the bill. If the discharge date is after September 30, 1990, Grouper assigns CMS DRG 480 and Pricer is able to price without using review code 08. If the discharge date is after September 30, 2007, Grouper assigns MS-DRG 005 or 006 (Liver transplant with MCC or Intestinal Transplant or Liver transplant without MCC, respectively) and Pricer is able to price without using review code 08.

4. Liver Transplant Billing From Non-approved Hospitals

Where a liver transplant and covered services are provided by a non-approved hospital, the bill data processed through Grouper and Pricer must exclude transplant procedure codes and related charges.

When CMS approves a hospital to furnish liver transplant services, it informs the hospital of the effective date in the approval letter. The contractor will receive a copy of the letter.