CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1895	**Date: January 15, 2010**
	Change Request 6547

Transmittal 1890, dated January 8, 2010, is being rescinded and replaced by Transmittal 1895, dated January 15, 2010 to remove Chapter 1, sections 60.1, 60.1.4 and 60.2. Those chapters were in the manual revision, but not listed on the transmittal page. All other material remains the same.

SUBJECT: Processing of Non-Covered International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) Procedure Codes on Inpatient Hospital Claims

I. SUMMARY OF CHANGES: Effective April 1, 2010, providers shall submit ICD-9 CM codes for non-covered procedures performed in the same inpatient stay with covered procedure(s) on a separate claim.

New / Revised Material
Effective Date: April 1, 2010
Implementation Date: April 5, 2010

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
N	1/60.2.1/Billing for Noncovered Procedures in an Inpatient Stay
R	3/20.2.1/Medicare Code Editor (MCE)

III. FUNDING:

SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

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.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment – Business Requirements

Pub. 100-04	Transmittal: 1895	Date: January 15, 2010	Change Request: 6547

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SUBJECT: Processing of Non-Covered International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) Procedure Codes on Inpatient Hospital Claims

Effective Date: April 1, 2010

Implementation Date: April 5, 2010

I. GENERAL INFORMATION

A. Background: Medicare uses ICD-9-CM codes to identify diagnoses and procedures in the hospital inpatient setting. Hospitals must report the principal diagnosis using the appropriate ICD-9-CM code, as well as any secondary diagnoses – some of which may be considered complications or comorbidities (CCs) or major complications or comorbidities (MCCs) for Medicare Severity-Diagnosis Related Group (MS-DRG) assignment. The circumstances of inpatient admission always govern selection of the principal diagnosis. Diagnosis codes should be reported to the highest level of specificity available – a code is invalid if it has not been coded to the full number of digits required for that code. For inpatient admissions involving procedures, hospitals must also report ICD-9-CM procedure code(s) for surgical and other procedures, up to six procedures on a claim.

All services and supplies provided during the inpatient admission are bundled into a single MS-DRG payment rate, regardless of the length of the inpatient stay, the intensity of treatments, or the number of procedures performed for the specific individual. Hospitals will receive one MS-DRG payment rate per inpatient admission. The MS-DRG assignment is determined by the patient's principal diagnosis, secondary diagnoses, and any procedures performed, as well as age, gender, and discharge disposition.

B. Policy: Effective April 1, 2010, providers shall submit ICD-9 CM codes for non-covered procedures performed in the same inpatient stay with covered procedure(s) on a separate claim.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes 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
							FISS	MCS	VMS	CWF	
6547.1	Effective for inpatient discharges on or after April 1, 2010, contractors shall educate hospitals to separate a hospital stay into two claims where both covered and non-covered ICD-9 CM procedure codes are reported:	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	
	• One claim with covered service(s)/procedure(s) unrelated to the non-covered ICD-9 CM procedure(s) on a Type of Bill (TOB) 11X (with the exception of 110), and • The other claim with the non-covered service(s)/procedure(s) on a TOB 110 (no-pay claim). **Note**: The Statement Covers Period shall match on both the covered and non-covered claim, as specified in Pub. 10-04, Chapter1, Section 60.1.4.										
6547.2	When either a processed or suspended claim is a TOB 110, FISS and CWF shall create a bypass on duplicate edits for an 11X TOB that has the following: • A matching Provider Number; and • A matching Health Insurance Claim Number (HICN); and • A matching Statement Covers Period .						X			X	
6547.3	Contractors shall RTP covered claims that receive MCE edit W0342, W0343, W0344, W1460, W1461, and W1462 requesting a no payment claim.	X		X							
6547.3.1	Contractors shall override the MCE edits listed in 6547.3 for non-covered claims.	X		X							
6547.4	Contractors shall deny claims submitted as non-covered with new reason codes created by FISS in 6547.4.1 and 6547.4.2.	X		X							
6547.4.1	FISS shall create a new reason code for such denials when a Hospital Issued Notice of Non-coverage (HINN) is not issued.						X				
6547.4.1.1	Contractors shall deny claims using the following: <u>Medicare Summary Notice:</u> **23.17** – Medicare won't cover these services because they are not considered medically necessary." **23.17** – Medicare no cubrirá estos servicios porque no son considerados necesarios por razones médicas. <u>Claim Adjustment Reason Code:</u>	X		X			X				MSN Work-Group

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	
	50 – These are non-covered services because this is not deemed a 'medical necessity" by the payer. Group Code: **CO** – Contractual Obligation										
6547.4.2	FISS shall create a new reason code for such denials when a HINN is applicable and properly issued.						X				
6547.4.2.1	Contractors shall deny claims using the following: Medicare Summary Notice: **23.17** – Medicare won't cover these services because they are not considered medically necessary." **23.17** – Medicare no cubrirá estos servicios porque no son considerados necesarios por razones médicas. Claim Adjustment Reason Code: **50** – These are non-covered services because this is not deemed a 'medical necessity" by the payer. Group Code: PR – Patient Responsibility	X		X			X				MSN Work-Group
6547.5	If applicable, contractors shall no longer remove non-covered procedure codes on the hospital's behalf, as was previously instructed in Pub. 100-04, Section 20.2.1, 12.	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	
6547.6	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	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	
	the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 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

Section A: For any recommendations and supporting information associated with listed requirements:

X-Ref Requirement Number	Recommendations or other supporting information:
6547.2	Multiple TOBs should be accounted for situations in which claims are separated into the following: • A covered claim (11X excluding 110), • A non-covered claim (110 with a 'N' no pay code), • A benefits exhaust claim (110 with a 'B' no pay code), and/or • A covered Part B of A claim (121).
6547.3.1 6547.4.1.1 6547.4.2.1	Contractors should consider performing the MCE override as well as denying non covered claims with the new FISS reason code using an Electronic Claims Processing System (ECPS) event(s).

Section B: For all other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s):
Valeri Ritter at 410-786-8652 or valeri.ritter@cms.hhs.gov and Joseph Bryson at 410-786-2986 or joseph.bryson@cms.hhs.gov

Post-Implementation Contact(s): Regional Office

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers*:

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

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.

Medicare Claims Processing Manual

Chapter 1 - General Billing Requirements

Table of Contents
(Rev.1895, 01-15-10)

60.2.1 – Billing for Non-covered Procedures in an Inpatient Stay
(Rev.1895, Issued: 01-15-10, Effective: 04-01-10, Implementation: 04-05-10)

As described in Section 1862 of the Social Security Act, providers are not to seek reimbursement for non-covered services/items. However, when a non-covered procedure is provided during an inpatient stay where a covered procedure is also performed, the claims processing system is unable to decipher what procedure code(s) is/are non-covered, so as to not consider such procedure(s) for payment (more specifically, to ignore non-covered procedures when grouping to the MS-DRG). Therefore, effective for inpatient discharges April 1, 2010, hospitals must only seek payment for covered services by removing non-covered procedure codes and related charges from the payable Type of Bill (TOB) 11X.

If a hospital wishes to bill non-covered procedure(s) and related non-covered charges for whatever reason (e.g., a Medicare denial), the hospital may submit such services/charges on a TOB 110 (no-pay claim). The non-covered claim must be billed with the same Statement Covers Period (From and Through date) as the payable TOB 11X submitted for the same stay.

Medicare Claims Processing Manual
Chapter 3 - Inpatient Hospital Billing

20.2.1 - Medicare Code Editor (MCE)
(Rev.1895, Issued: 01-15-10, Effective: 04-01-10, Implementation: 04-05-10)

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 *that the non-covered procedure and its associated charges be removed from the covered claim, Type of Bill (TOB) 11X. If the hospital wishes to receive a Medicare denial, etc., the hospital may submit a non-covered claim, TOB 110, with the non-covered procedure/charges. (For more information on billing non-pay claims, see Chapter 1 of this Manual, Section 60.1.4).*

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.

20 – Limited Coverage

Effective October 1, 2003, for certain procedures whose medical complexity and serious nature incur extraordinary associated costs, Medicare limits coverage. The edit message indicates the type of limited coverage (e.g., LVRS, heart transplant, etc). The procedures receiving limited coverage edits previously were listed as non-covered procedures, but were covered under Medicare in certain circumstances. The FIs will handle these procedures as they had previously.