CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 3030	**Date: August 22, 2014**
	Change Request 8679

SUBJECT: Update to Pub. 100-04, Chapter 03 to Provide Language-Only Changes for Updating ICD-10 and ASC X12

I. SUMMARY OF CHANGES: This Change Request contains language-only changes for updating ICD-10 and ASC X12 language in Pub 100-04, Chapter 3. Additionally, references to CMS contractor types have been replaced with Medicare Administrative Contractors (MACs) in the sections that are updated by this transmittal. Also, the list of legacy identifiers for swing-beds has been expanded to include the "Z" for CAH swing-beds. There are no new coverage policies, payment policies, or codes introduced in this transmittal. Specific policy changes and related business requirements have been announced previously in various communications.

EFFECTIVE DATE: ASC X12: January 1, 2012; ICD-10: Upon Implementation of ICD-10
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: ICD-10: Upon Implementation of ICD-10; ASC X12: September 23, 2014 issuance

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

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	03/Table of Contents
R	3/10.1/ Claim Formats
R	03/10.4/ Payment of Nonphysician Services for Inpatients
R	03/20.1.2/ Outliers
R	03/20.1.2.10/ Return Codes for Pricer
R	03/20.2/ Computer Programs Used to Support Prospective Payment System
R	03/20.2.1/ Medicare Code Editor (MCE)
R	03/20.2.2/ DRG Grouper Program
R	03/20.7.3/ Payment for Blood Clotting Factor Administered to Hemophilia Inpatients
R	03/30.1.2/ Payment for Post Hospital SNF Care Furnished by a CAH
R	03/40.2.1/ Noncovered Admission Followed by Covered Level of Care
R	03/40.3/ Outpatient Services Treated as Inpatient Services
R	03/50/ Adjustment Bills
R	03/50.1/ Tolerance Guidelines for Submitting Adjustment Requests
R	03/50.2/ Claim Change Reasons
R	03/60/ Swing-Bed Services
R	03/70.1/ Providers Using All Inclusive Rates for Inpatient Part A Charges
R	03/90.1.1/ The Standard Kidney Acquisition Charge
R	03/90.1.2/ Billing for Kidney Transplantation and Acquisition Services
R	03/90.2/ Heart Transplants
R	03/90.2.1/ Artificial Hearts and Related Devices
R	03/90.3/ Stem Cell Transplantation
R	03/90.3.1/ Allogeneic Stem Cell Transplantation
R	03/90.3.2/ Autologous Stem Cell Transplantation (AuSCT)
R	03/90.3.3/ Billing for Stem Cell Transplantation
R	03/90.4.2/ Billing for Liver Transplant and Acquisition Services
R	03/90.5/ Pancreas Transplants Kidney Transplants
R	03/90.6/ Intestinal and Multi-Visceral Transplants
R	03/100.1/ Billing for Abortion Services
R	03/100.7/ Lung Volume Reduction Surgery
R	03/110.9/ Nonemergency Part B Medical and Other Health Services

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	03/110.11/ Elections to Bill for Services Rendered Nonparticipating Hospitals
R	03/140.1.3/ Verification Process Used To Determine If the Inpatient Rehabilitation Facility Met The Classification Criteria
R	03/140.3/ Billing Requirements Under IRF PPS
R	03/140.3.3/ Remittance Advices
R	03/150.7/ Patient Classification System
R	03/150.12.1/ Processing Bills Between October 1, 2002 and the Implementation Date
R	03/150.13/ Billing Requirements Under LTCH PPS
R	03/150.16/ Billing Ancillary Services Under LTCH PPS
R	03/160.1.1/ Identifying Claims Eligible for the Add-On Payment for New Technology
R	03/170.1.3/ Completion of the Notice of Election for RNHCI
R	03/170.2.2/ Required Data Elements on Clams for RNHCI Services
R	03/180.1/ Recording Determinations of Excepted/Nonexcepted Care on Claim Records
R	03/190.4.3/ Annual Update
R	03/190.5.1/ Diagnosis Related Groups (DRGs) Adjustments
R	03/190.5.2/ Application of Code First
R	03/190.5.3/ Comorbidity Adjustments
R	03/190.6.4.1/ Source of Admission for IPF PPS Claims for Payment of ED Adjustment
R	03/190.7.3/ Electroconvulsive Therapy (ECT) Payment
R	03/190.10.1/ General Rules
R	03/190.10.4/ Reporting ECT Treatments
D	3/ Attachment A

III. FUNDING:

For Medicare Administrative Contractors (MACs):

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

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 3030	Date: August 22, 2014	Change Request: 8679

SUBJECT: Update to Pub. 100-04, Chapter 03 to Provide Language-Only Changes for Updating ICD-10 and ASC X12

EFFECTIVE DATE: ICD-10: Upon Implementation of ICD-10; ASC X12: January 1, 2012
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: ICD-10: Upon Implementation of ICD-10; ASC X12: September 23, 2014

I. GENERAL INFORMATION

A. Background: Update to Pub. 100-04, Chapter 03 to Provide Language-Only Changes for Updating ICD-10 and ASC X12

B. Policy: *Additionally, references to CMS contractor types have been replaced with Medicare Administrative Contractors (MACs) in the sections that are updated by this transmittal. There are no new coverage policies, payment policies, or codes introduced in this transmittal. Specific policy changes and related business requirements have been announced previously in various communications.*

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
8679.1	A/B MACs shall be aware of the updated language for ICD-10 and for ASC X12 in Pub. 100 - 04, Chapter 03.	X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Not Applicable, 123-456-7890

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

VI. FUNDING

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

ATTACHMENTS: 0

Medicare Claims Processing Manual

Chapter 3 - Inpatient Hospital Billing

Table of Contents

(Rev. 3030, Issued: 08-22-14)

Medicare Claims Processing Manual
Chapter 3 - Inpatient Hospital Billing

10.1 – *Claim Formats*
(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD -10, Implementation: ICD -10: Upon Implementation of ICD -10, ASC X12: September, 23 2014)

A. - Institutional Claim Formats

The ASC X12 837 institutional claim format, or where permissible, Form CMS-1450, Inpatient and/or Outpatient Billing, is used for all provider billing, except for the professional component of physicians services. *(Refer to paragraph B for the appropriate professional claim formats.) The ASC X12 837 institutional claim format and Form CMS-1450 are processed by the provider's A/B MAC (A).* See Chapter 25 for instructions for hospital services.)

Providers *submitting claims on paper* are responsible for purchasing their own *paper* forms.

B. - Professional Claim Formats

The ASC X12 837 professional claim format, or where permissible, Form CMS-1500 is the prescribed form*at* for claims prepared by physicians *and nonphysician practitioners* whether or not the claims are assigned. Institutional providers may use the *ASC X12 837 professional claim format or the* Form CMS-1500 to bill the *A/B MAC (B)* for the professional component of physicians' services where applicable. *(For more information about the CMS-1500 claim form, refer to Chapter 26. Information about billing for physician and other supplier services can be found in this chapter as well as chapters throughout this manual relative to specific policies and topics.)*

Providers submitting claims on paper are responsible for purchasing their own paper forms.

C. - **Form CMS-1490S Patient's Request for Medicare Payment**

Only beneficiaries (or their representatives) who complete and file their own claims use this *form*. Providers have no need for this form.

10.4 - Payment of Nonphysician Services for Inpatients
(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD -10, Implementation: ICD -10: Upon Implementation of ICD -10, ASC X12: September, 23 2014)

All items and nonphysician services furnished to inpatients must be furnished directly by the hospital or billed through the hospital under arrangements. This provision applies to all hospitals, regardless of whether they are subject to PPS.

A. - Other Medical Items, Supplies, and Services

The following medical items, supplies, and services furnished to inpatients are covered under Part A. Consequently, they are covered by the prospective payment rate or reimbursed as reasonable costs under Part A to hospitals excluded from PPS.

- Laboratory services (excluding anatomic pathology services and certain clinical pathology services);
- Pacemakers and other prosthetic devices including lenses, and artificial limbs, knees, and hips;

- Radiology services including computed tomography (CT) scans furnished to inpatients by a physician's office, other hospital, or radiology clinic;

- Total parenteral nutrition (TPN) services; and

- Transportation, including transportation by ambulance, to and from another hospital or freestanding facility to receive specialized diagnostic or therapeutic services not available at the facility where the patient is an inpatient.

The hospital must include the cost of these services in the appropriate ancillary service cost center, i.e., in the cost of the diagnostic or therapeutic service. It must not show them separately under revenue code 0540.

EXCEPTIONS:

- **Pneumococcal Vaccine -** is payable under Part B only and is billed by the hospital *using the ASC X12 837 institutional claim format* or on the Form CMS-1450.

- **Ambulance Service** - For purposes of this section "hospital inpatient" means a beneficiary who has been formally admitted it does not include a beneficiary who is in the process of being transferred from one hospital to another. Where the patient is transferred from one hospital to another, and is admitted as an inpatient to the second, the ambulance service is payable under only Part B. If transportation is by a hospital owned and operated ambulance, the hospital bills separately *using the ASC X12 837 institutional claim format* or on Form CMS-1450 as appropriate. Similarly, if the hospital arranges for the ambulance transportation with an ambulance operator, including paying the ambulance operator, it bills separately. However, if the hospital does not assume any financial responsibility, the billing is to the *A/B MAC (B)* by the ambulance operator or beneficiary, as appropriate, if an ambulance is used for the transportation of a hospital inpatient to another facility for diagnostic tests or special treatment the ambulance trip is considered part of the DRG, and not separately billable, if the resident hospital is under PPS.

- **Part B Inpatient Services** - Where Part A benefits are not payable, payment may be made to the hospital under Part B for certain medical and other health services. See Chapter 4 for a description of Part B inpatient services.

- **Anesthetist Services "Incident to" Physician Services** - If a physician's practice was to employ anesthetists and to bill on a reasonable charge basis for these services and that practice was in effect as of the last day of the hospital's most recent 12-month cost reporting period ending before September 30, 1983, the physician may continue that practice through cost reporting periods beginning October 1, 1984. However, if the physician chooses to continue this practice, the hospital may not add costs of the anesthetist’s service to its base period costs for purposes of its transition payment rates. If it is the existing or new practice of the physician to employ certified registered nurse anesthetists (CRNAs) and other qualified anesthetists and include charges for their services in the physician bills for anesthesiology services for the hospital's cost report periods beginning on or after October 1, 1984, and before October 1, 1987, the physician may continue to do so.

B. - Exceptions/Waivers

These provisions were waived before cost reporting periods beginning on or after October 1, 1986, under certain circumstances. The basic criteria for waiver was that services furnished by outside suppliers are so extensive that a sudden change in billing practices would threaten the stability of patient care. Specific criteria for waiver and processing procedures are in §2804 of the Provider Reimbursement Manual (CMS Pub. 15-1).

20.1.2 - Outliers

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD -10, Implementation: ICD -10: Upon Implementation of ICD -10, ASC X12: September, 23 2014)

§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 Medicare contractor using Pricer, which takes into account both operating and capital costs and Medicare severity-diagnostic related group (MS-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 MS-DRGs). Any outlier payment due is added to the MS-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 *the CMS* Web site at

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html

The Medicare contractor 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.

20.1.2.10 - Return Codes for Pricer

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD -10, Implementation: ICD -10: Upon Implementation of ICD -10, ASC X12: September, 23 2014)

The following return codes are calculated by PRICER and passed back to the calling program. Depending on the type of payment and case, return codes 30, 44, 33, 40 and 42 indicate that an outlier would be paid if the cost-to-charge ratio would rise by 20 percentage points. If a provider(s) (CCR rises by 10 percentage points and) meets the criteria of reconciliation, the CMS Central Office uses return codes 30, 44, 33, 40 and 42 to determine a smaller pool of claims for reprocessing claims due to outlier reconciliation.

Acute Care

Return Code 00: Paid normal DRG payment.

Return Code 02: Paid normal DRG payment plus a cost outlier.

Return Code 14: Paid normal DRG payment with per diem days equal or greater than geometric mean length of stay.

Return Code 16: Paid normal DRG payment plus a cost outlier with per diem days equal to or greater than geometric mean length of stay.

Return Code 30: Paid normal DRG payment and indicates an outlier payment would be necessary if the CCR would increase by 20 percentage points.

Return Code 44: Paid normal DRG payment with per diem days equal or greater than geometric mean length of stay and indicates an outlier payment would be necessary if the CCR would increase by 20 percentage points.

Transfer Cases

Return Code 03: Paid a per diem payment to the transferring IPPS hospital (when the patient transfers to an IPPS hospital) up to and including the full DRG payment if the covered days are less than the geometric mean length of stay for the DRG. If covered days equal or exceed the geometric mean length of stay, the standard payment is calculated.

Return Code 05: Paid a per diem payment to the transferring IPPS hospital (when the patient transfers to an IPPS hospital) up to and including the full DRG payment if the covered days are less than the geometric mean length of stay for the DRG. If covered days equal or exceed the geometric mean length of stay, the standard payment is calculated. Also indicates case qualified for a cost outlier payment.

Return Code 06: Paid a per diem payment to the transferring IPPS hospital (when the patient transfers to an IPPS hospital) up to and including the full DRG payment if the covered days are less than the geometric mean length of stay for the DRG. If covered days equal or exceed the geometric mean length of stay, the standard payment is calculated. Also indicates provider refused cost outlier payment.

Return Code 33: Paid a per diem payment to the transferring IPPS hospital (when the patient transfers to an IPPS hospital) up to and including the full DRG payment if the covered days are less than the geometric mean length of stay for the DRG. If covered days equal or exceed the geometric mean length of stay, the standard payment is calculated. Also indicates an outlier payment would be necessary if the CCR increased by 20 percentage points.

Postacute Transfer Cases

Return Code 10: Makes payment to the transferring IPPS hospital (when the patient transfers to a non-IPPS hospital) for postacute transfer DRGs (that have double the payment on the 1st day for purposes of the postacute care transfer policy) as published in the annual IPPS Final Rule. Will calculate a per diem payment based on the standard DRG payment if the covered days are less than the geometric mean length of stay for the DRG. If covered days equal or exceed the geometric mean length of stay the standard payment is also calculated. The cost outlier portion of the payment is calculated if the adjusted charges on the bill exceed the outlier threshold.

Return Code 12: Makes payment to the transferring IPPS hospital (when the patient transfers to a non-IPPS hospital) for postacute transfer DRGs (that receive 50 percent of the prospective payment on the 1st day of the stay for purposes of the postacute care transfer policy) as published in the annual IPPS Final Rule. Will calculate a per diem payment based on the standard DRG payment if the covered days are less than the geometric mean length of stay for the DRG. If covered days equal or exceed the geometric mean length of stay, the standard payment is calculated. The cost outlier portion of the payment is calculated if the adjusted charges on the bill exceed the outlier threshold.

Return Code 40: Makes payment to the transferring IPPS hospital (when the patient transfers to a non-IPPS hospital) for *postacute* transfer DRGs (that have double the payment on the 1st day for purposes of the postacute care transfer policy) as published in the annual IPPS Final Rule. Will calculate a per diem payment based on the standard DRG payment if the covered days are less than the geometric mean length of

stay for the DRG. If covered days equal or exceed the geometric mean length of stay, the standard payment is calculated. Also indicates an outlier payment would be necessary if the CCR increased by 20 percentage points.

Return Code 42: Makes payment to the transferring IPPS hospital (when the patient transfers to a non-IPPS hospital) for *postacute* transfer DRGs (that receive 50 percent of the prospective payment on the 1st day of the stay for purposes of the postacute care transfer policy) as published in the annual IPPS Final Rule. Will calculate a per diem payment based on the standard DRG payment if the covered days are less than the geometric mean length of stay for the DRG. If covered days equal or exceed the geometric mean length of stay, the standard payment is calculated. Also indicates an outlier payment would be necessary if the CCR increased by 20 percentage points.

20.2 - Computer Programs Used to Support Prospective Payment System

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD -10, Implementation: ICD -10: Upon Implementation of ICD -10, ASC X12: September, 23 2014)

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 *diagnosis and procedure* 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 *(A)*, 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.gov/Medicare/Medicare-Fee-for-Service-Payment/PCPricer/inpatient.html .

20.2.1 - Medicare Code Editor (MCE)

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD -10, Implementation: ICD -10: Upon Implementation of ICD -10, ASC X12: September, 23 2014)

A. - General

The MCE edits claims to detect incorrect billing data. In determining the appropriate MS-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 MS-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 MS-DRG assignment:

- **Code Edits -** Examines a record for the correct use of *diagnosis and procedure codes.* 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 *A/B* MAC *(A)* 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 (*condition* code C1 or C3). 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 *A/B* MAC *(A)* 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 (25 maximum – principal diagnosis and up to 24 additional diagnoses);
- Procedures (25 maximum); and
- Discharge date.

The MCE provides the *A/B* MAC *(A)* an analysis of "errors" on the bill as described in subsection D. The *A/B* MAC *(A)* 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 *A/B* MAC *(A)* considers the bill improperly completed for control and processing time purposes. (See chapter 1.)

NOTE: *The following instructions are based on ICD-9-CM diagnosis and procedure codes.* ***Applicable*** *ICD-10-CM and ICD-10-PCS codes will be provided as part of the annual updates when ICD-10 is implemented.*

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 *diagnosis and procedure* 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 *A/B* MAC *(A)* returns the bill to the provider.

For a list of valid *diagnosis or procedure* codes see *the* "International Classification of Diseases*" revision applicable to the date of the inpatient discharge or other service* and the "Addendum/Errata" and new codes furnished by the *A/B MAC (A)*. The hospital must review the medical record and/or face sheet and enter the correct diagnosis/procedure codes before returning the bill.

2. - ***External Cause of Injury*** **Code as Principal Diagnosis**

External Cause of Injury 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. *In* ICD-9-CM the external cause of injury diagnosis codes begin with the letter E. *In ICD-10-CM the external cause of injury codes begin with the letters V, W, X and Y.* For a list of all E*xternal cause of injury* codes, see "International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), January 1979, Volume l (Diseases)" *and the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM).* The hospital must review the medical record and/or face sheet and enter the correct diagnosis before returning the bill.

3. - 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 *A/B MAC (A)* will delete the duplicate secondary diagnosis and process the bill.

4. - 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 list of diagnoses that are acceptable for each age category can be located in the most current version of the MCE, which is posted at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FY_14_Definition_of-Medicare_Code_Edits_V_31_Manual.pdf

If the *A/B MAC (A)* edits online, it will return such bills for a proper diagnosis or correction of age as applicable. If the *A/B MAC (A)* 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.

5. - 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 MCE contains listings of male and female related 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.

6. - 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 MCE contains listings of diagnosis *codes* identified as manifestation codes. The hospital should review the medical record and/or face sheet and enter the proper diagnosis before returning the bill.

7. - 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.

8. - Questionable Admission

There are some diagnoses which are not usually sufficient justification for admission to an acute care hospital.

The MCE contains a listing of diagnosis codes identified as "Questionable Admission" when used as principal diagnosis.

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

9. - 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, *the diagnosis code for family history of a certain disease would be* an unacceptable principal diagnosis *since the patient may not have the disease.*

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 *(A)* may review claims with *specific codes in the Unacceptable Principal Diagnosis section* and a secondary diagnosis. A/B MACs *(A)* 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 *A/B MAC (A)* 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.

10. - 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.

11. - Noncovered O.R. Procedures

There are some O.R. procedures for which Medicare does not provide payment.
The *A/B MAC (A)* 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).

12. - Open Biopsy Check

Biopsies can be performed as open (i.e., a body cavity is entered surgically), percutaneously, or endoscopically. The MS-DRG Grouper logic assign a patient to different MS-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 *diagnosis* codes correctly, the *A/B MAC (A)* 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 *A/B MAC (A)* 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 *A/B MAC (A)* assigns the appropriate closed biopsy code after reviewing the medical information.

Effective October 1, 2010, the open biopsy check edit was discontinued and was only used when processing MCE version 2.0 – 26.0.

Effective with the implementation of ICD-10, ICD-10-PCS codes will be implemented which clearly identify in greater detail the approach used in the biopsy.

13. - 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 *A/B MAC (A)* 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 *A/B MAC (A)* may develop claims prior to payment on a provider-specific basis.

Effective with the implementation of ICD-10, ICD-10-PCS codes will be implemented which clearly identify the exact joint (left or right). Reporting these two more precise ICD-10-PCS will clearly indicate if a bilateral procedure is performed.

14. - Invalid Age

If the hospital reports an age over l24, the *A/B MAC (A)* 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.

15. - Invalid Sex

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

16. - Invalid Discharge Status

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

17. - 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.

18 - 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 *A/B* MACs *(A)* will handle these procedures as they had previously.

19 - Procedure inconsistent with length of stay

Effective October 1, 2012, the following *ICD-9-CM* procedure code should only be coded on claims with a length of stay of four days or greater.

96.72 Continuous invasive mechanical ventilation for 96 consecutive hours or more

Effective with the implementation of ICD-10, the following ICD-10-PCS code captures this information.

5A1955Z - Respiratory Ventilation, Greater than 96 Consecutive Hours

20.2.2 - DRG GROUPER Program

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD -10, Implementation: ICD -10: Upon Implementation of ICD -10, ASC X12: September, 23 2014)

The *A/B MAC (A)* pays for inpatient hospital services on the basis of a rate per discharge that varies according to the MS-DRG to which a beneficiary's stay is assigned. Each MS-DRG represents the average resources required to care for a case in that particular MS-DRG relative to the national average of resources consumed per case. The MS-DRG weights used to calculate payment are in the Pricer DRGX file.

The *A/B MAC (A)* uses the GROUPER program to assign the MS-DRG number. GROUPER determines the MS-DRG from data elements reported by the hospital. This applies to 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.

The Pricer (PPSMAIN) driver program calls the correct fiscal year GROUPER based upon the discharge date. If the *A/B MAC (A)* or shared system writes its own driver program, it must access the GROUPER for the correct FY based on discharge date. GROUPER does not determine the MS-DRG price. GROUPER input/output are specified below. The *A/B MAC (A)* determines the best place in its total system to place the GROUPER program.

Grouper requires the following items:

1 - Principal and up to 24 other diagnoses

2 - Principal and up to 24 additional procedures

3 - Age at last birthday at admission

4 - Sex (1=male and 2=female)

5 - Discharge destination (patient status code from the claim)

The claim sex coding is M for male and F for female while GROUPER is l for male and 2 for female. Discharge destination codes are similar to claim definitions for patient status except codes 20-29 are

summarized as 20. The *A/B MAC (A)* calculates age at admission. GROUPER needs age rather than date of birth.

Grouper responds with the following information:

1 - Major diagnostic category

2 - MS-DRG number

3 - Grouper return code (a one position code indicating the action taken by the program)

4 - Procedure code used in determining the MS-DRG

5 - Diagnosis code used in determining the MS-DRG

6 - Secondary diagnosis code used in determining the MS-DRG, if applicable

20.7.3 - Payment for Blood Clotting Factor Administered to Hemophilia Inpatients

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD -10, Implementation: ICD -10: Upon Implementation of ICD -10, ASC X12: September, 23 2014)

Section 6011 of Public Law (P.L.) 101-239 amended §1886(a)(4) of the Social Security Act (the Act) to provide that prospective payment system (PPS) hospitals receive an additional payment for the costs of administering blood clotting factor to Medicare hemophiliacs who are hospital inpatients. Section 6011(b) of P.L. 101.239 specified that the payment be based on a predetermined price per unit of clotting factor multiplied by the number of units provided. This add-on payment originally was effective for blood clotting factors furnished on or after June 19, 1990, and before December 19, 1991. Section 13505 of P. L. 103-66 amended §6011 (d) of P.L. 101-239 to extend the period covered by the add-on payment for blood clotting factors administered to Medicare inpatients with hemophilia through September 30, 1994. Section 4452 of P.L. 105-33 amended §6011(d) of P.L. 101-239 to reinstate the add-on payment for the costs of administering blood-clotting factor to Medicare beneficiaries who have hemophilia and who are hospital inpatients for discharges occurring on or after October 1, 1998.

A/B MACs (B) shall process non-institutional blood clotting factor claims.

The *A/B MACs (A)* shall process institutional blood clotting factor claims payable under either Part A or Part B.

A. - Inpatient Bills

Under the Inpatient Prospective Payment System (IPPS), hospitals receive a special add-on payment for the costs of furnishing blood clotting factors to Medicare beneficiaries with hemophilia, admitted as inpatients of PPS hospitals. The clotting factor add-on payment is calculated using the number of units (as defined in the HCPCS code long descriptor) billed by the provider under special instructions for units of service.

The PPS Pricer software does not calculate the payment amount. The Fiscal Intermediary Shared System (FISS) calculates the payment amount and subtracts the charges from those submitted to Pricer so that the clotting factor charges are not included in cost outlier computations.

Blood clotting factors not paid on a cost or PPS basis are priced as a drug/biological under the Medicare Part B Drug Pricing File effective for the specific date of service. As of January 1, 2005, the average sales price (ASP) plus 6 percent shall be used.

If a beneficiary is in a covered Part A stay in a PPS hospital, the clotting factors are paid in addition to the DRG/HIPPS payment (For FY 2004, this payment is based on 95 percent of average wholesale price.) For a SNF subject to SNF/PPS, the payment is bundled into the SNF/PPS rate.

For SNF inpatient Part A, there is no add-on payment for blood clotting factors.

The codes for blood-clotting factors are found on the Medicare Part B Drug Pricing File. This file is distributed on a quarterly basis.

For discharges occurring on or after October 1, 2000, and before December 31, 2005, report HCPCS Q0187 based on 1 billing unit per 1.2 mg. Effective January 1, 2006, HCPCS code J7189 replaces Q0187 and is defined as 1 billing unit per 1 microgram (mcg).

The examples below include the HCPCS code and indicate the dosage amount specified in the descriptor of that code. Facilities use the units field as a multiplier to arrive at the dosage amount.

EXAMPLE 1

HCPCS	Drug	Dosage
J7189	Factor VIIa	1 mcg

Actual dosage: 13,365 mcg

On the bill, the facility shows J7189 and 13,365 in the units field (13,365 mcg divided by 1 mcg = 13,365 units).

NOTE: The process for dealing with one international unit (IU) is the same as the process of dealing with one microgram.

EXAMPLE 2

HCPCS	Drug	Dosage
J9355	Trastuzumab	10 mg

Actual dosage: 140 mg

On the bill, the facility shows J9355 and 14 in the units field (140 mg divided by 10mg = 14 units).

When the dosage amount is greater than the amount indicated for the HCPCS code, the facility rounds up to determine units. When the dosage amount is less than the amount indicated for the HCPCS code, use 1 as the unit of measure.

EXAMPLE 3

HCPCS	Drug	Dosage
J3100	Tenecteplase	50 mg

Actual Dosage: 40 mg

The provider would bill for 1 unit, even though less than 1 full unit was furnished.

At times, the facility provides less than the amount provided in a single use vial and there is waste, i.e.; some drugs may be available only in packaged amounts that exceed the needs of an individual patient. Once the drug is reconstituted in the hospital's pharmacy, it may have a limited shelf life. Since an individual patient may receive less than the fully reconstituted amount, we encourage hospitals to schedule patients in such a

way that the hospital can use the drug most efficiently. However, if the hospital must discard the remainder of a vial after administering part of it to a Medicare patient, the provider may bill for the amount of drug discarded plus the amount administered.

Example 1:

Drug X is available only in a 100-unit size. A hospital schedules three Medicare patients to receive drug X on the same day within the designated shelf life of the product. An appropriate hospital staff member administers 30 units to each patient. The remaining 10 units are billed to Medicare on the account of the last patient. Therefore, 30 units are billed on behalf of the first patient seen and 30 units are billed on behalf of the second patient seen. Forty units are billed on behalf of the last patient seen because the hospital had to discard 10 units at that point.

Example 2:

An appropriate hospital staff member must administer 30 units of drug X to a Medicare patient, and it is not practical to schedule another patient who requires the same drug. For example, the hospital has only one patient who requires drug X, or the hospital sees the patient for the first time and did not know the patient's condition. The hospital bills for 100 units on behalf of the patient, and Medicare pays for 100 units.

When the number of units of blood clotting factor administered to hemophiliac inpatients exceeds 99,999, the hospital reports the excess as a second line for revenue code 0636 and repeats the HCPCS code. One hundred thousand fifty (100,050) units are reported on one line as 99,999, and another line shows 1,051.

Revenue Code 0636 is used. It requires HCPCS. Some other inpatient drugs continue to be billed without HCPCS codes under pharmacy.

No changes in beneficiary notices are required. Coverage is applicable to hospital Part A claims only. Coverage is also applicable to inpatient Part B services in SNFs and all types of hospitals, including CAHs. Separate payment is not made to SNFs for beneficiaries in an inpatient Part A stay.

B. - A/B MAC *(A)* Action

The contractor is responsible for the following:

- It accepts HCPCS codes for inpatient services;
- It edits to require HCPCS codes with Revenue Code 0636. Multiple iterations of the revenue code are possible with the same or different HCPCS codes. It does not edit units except to ensure a numeric value;
- It reduces charges forwarded to Pricer by the charges for hemophilia clotting factors in revenue code 0636. It retains the charges and revenue and HCPCS codes for CWF; and
- It modifies data entry screens to accept HCPCS codes for hospital (including CAH) swing bed, and SNF inpatient claims (bill types 11X, 12X, 18x, 21x and, 22x).

The September 1, 1993, IPPS final rule (58 FR 46304) states that payment will be made for the blood clotting factor only if diagnosis code for hemophilia is included on the bill.

Inpatient blood-clotting factors are covered only for beneficiaries with hemophilia. One of the following hemophilia diagnosis codes must be reported on the claim for payment to be made for blood clotting factors.

Table 1 - Effective for discharges September 1 1993 through the implementation of ICD-10

ICD-9-CM code	***Description***
286.0	*Congenital factor VIII disorder*
286.1	*Congenital factor IX disorder*
286.2	*Congenital factor XI deficiency*
286.3	*Congenital deficiency of other clotting factors*
286.4	*von Willebrands' disease*

Table 2 - Effective for discharges August 1, 2001 through the implementation of ICD-10*, payment may be made if a diagnosis codes from either Table 1 or Table 2 is reported is reported:*

ICD-9-CM code	***Description***
286.5	*Hemorrhagic disorder due to intrinsic circulating anticoagulants (terminate effective September 30, 2011)*
286.7	*Acquired coagulation factor deficiency*

Table 3 - Effective for discharges on October 1, 2011, through the implementation of ICD-10 *payment may be made if a diagnosis code from any of Table 1, Table 2 or Table 3 is reported:*

ICD-9-CM code	***Description***
286.52	*Acquired hemophilia*
286.53	*Antiphospholipid antibody with hemorrhagic disorder*
286.59	*Other hemorrhagic disorder due to intrinsic circulating anticoagulants, antibodies, or inhibitors*

Effective for discharges on or after the implementation of *ICD-10-CM, the following codes are applicable, and payment may be made for blood clotting factors only if a hemophilia code from the range D66 - D68.4 is reported*

A crosswalk of ICD 9 to ICD10 hemophilia diagnosis codes follows:

ICD-9-CM Code	**Description**	**ICD-10-CM Code**	**Description**
286.0	*Congenital factor VIII disorder*	*D66*	*Hereditary factor VIII deficiency*
286.1	*Congenital factor IX disorder*	*D67*	*Hereditary factor IX deficiency*
286.2	*Congenital factor XI deficiency*	*D68.1*	*Hereditary factor XI deficiency*
286.3	*Congenital deficiency of other clotting factors*	*D68.2*	*Hereditary deficiency of other clotting factors*
286.4	*von Willebrands' disease*	*D68.0*	*Von Willebrand's disease*
286.5	*Hemorrhagic disorder due to*	*N/A*	

ICD-9-CM Code	Description	ICD-10-CM Code	Description
	intrinsic circulating anticoagulants (terminate effective September 30, 2011)		
286.52	*Acquired hemophilia*	*D68.311*	*Acquired hemophilia*
286.53	*Antiphospholipid antibody with hemorrhagic disorder*	*D68.312*	*Antiphospholipid antibody with hemorrhagic disorder*
286.59	*Other hemorrhagic disorder due to intrinsic circulating anticoagulants, antibodies, or inhibitors*	*D68.318*	*Other hemorrhagic disorder due to intrinsic circulating anticoagulants, antibodies, or inhibitors*
286.7	*Acquired coagulation factor deficiency*	*D68.32*	*Antiphospholipid antibody with hemorrhagic disorder*
286.7	*Acquired coagulation factor deficiency*	*D68.4*	*Acquired coagulation factor deficiency*

C. - Part A Remittance Advice

For remittance reporting PIP and/or non-PIP payments, the Hemophilia Add On *is included in the overall claim payment (Provider Reimbursement, CLP04).*

If an inpatient claim has a Hemophilia Add On payment, the payment to the provider is increased in the PLB segment with a PLB adjustment HM. The Hemophilia Add On amount will always be included in the CLP04 Claim Payment Amount.

For remittance reporting PIP payments, the Hemophilia Add On will also be reported in the provider level adjustment (element identifier PLB) segment with the provider level adjustment reason code *HM.* For remittances reporting PIP payments, *the sum of inpatient claims, CLP04, is backed out at PLB with PI/PA. If an inpatient claim has a Hemophilia Add On payment, the payment to the provider is increased in the PLB segment with a PLB adjustment HM.*

D. **- Standard Hard Copy Remittance Advice**

For paper remittances reporting non-PIP payments involving Hemophilia Add On, add a "Hemophilia Add On" category to the end of the "Pass Thru Amounts" listings in the "Summary" section of the paper remittance. Enter the total of the Hemophilia Add On amounts due for the claims covered by this remittance next to the Hemophilia Add On heading.

Contractors add the Remark Code “MA103” (Hemophilia Add On) to the remittance advice under the REM column for those claims that qualify for Hemophilia Add On payments.

This will be the full extent of Hemophilia Add On reporting on paper remittance notices; providers wishing more detailed information must subscribe to the Medicare Part A specifications for the *ASC* X12 835 *remittance advice*, where additional information is available.

See chapter 22, for detailed instructions and definitions.

30.1.2 - Payment for Post-Hospital SNF Care Furnished by a CAH

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD -10, Implementation: ICD -10: Upon Implementation of ICD -10, ASC X12: September, 23 2014)

The SNF-level services provided by a CAH, are paid at 101% of reasonable cost. Since this is consistent with the reasonable cost principles, *A/B MACs (A)* **will now** pay for those services at 101% reasonable cost. Hospitals must follow the rules for payment in §60 for swing-bed services.

Coinsurance and deductible are applicable for inpatient CAH payment.

All items on the ASC X12 837 institutional claim format are completed in accord with the implementation guide applicable to the dates of the stay. All items on Form CMS-1450 are completed in accordance with Chapter 25.

40.2.1 - Noncovered Admission Followed by Covered Level of Care

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD -10, Implementation: ICD -10: Upon Implementation of ICD -10, ASC X12: September, 23 2014)

Where a beneficiary receives noncovered care at admission, and is notified as such, but subsequently is furnished covered level of care during the same hospital stay, the admission is deemed to have occurred when covered services became medically needed and rendered. This is applicable to PPS and non-PPS billings.

The following billing entries identify this situation:

- Admission date (not the deemed date).
- Occurrence code "31" and the date the hospital provided notice to the beneficiary.
- Occurrence span code 76 indicates the noncovered span from admission date through the day before covered care started.
- Value code 31 is used to indicate the amount which was charged the beneficiary for noncovered services.
- Noncovered charges related to the noncovered services.
- The principal diagnosis is shown as the diagnosis that caused the covered level of care.
- Only procedures performed during the covered level of care are shown on the bill.

If a no payment bill for the noncovered level of care has been processed, the hospital prepares and forwards a new initial bill.

40.2.6 - Leave of Absence

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD -10, Implementation: ICD -10: Upon Implementation of ICD -10, ASC X12: September, 23 2014)

Providers submit one bill for covered days and days of leave when the patient is ultimately discharged.

The provider bills for covered days with days of leave included in Noncovered Days. Noncovered charges for leave of absence days (holding a bed) may be omitted from the bill or may be shown under revenue code 018x. Providers will be instructed by their *A/B MAC (A)* on which billing method to use. Occurrence span code 74 is used to report the dates the leave began and ended. Although the Medicare program may not be billed for days of leave, the provider is not permitted to charge a beneficiary for them.

Where a patient on leave of absence from a non-PPS hospital who was shown as "Still Patient" (patient status code 30) on an interim bill:

- Has not returned within 60 days, including the day leave began, or

- Has been admitted to another institution at any time during the leave of absence, submit an adjusted bill.

The hospital shows the day the patient left the hospital as the date of discharge. (A beneficiary cannot be an inpatient of two institutions at the same time.)

NOTE: Home health or outpatient services provided during a leave of absence do not affect the leave and no discharge bill is required unless the above events occur.

40.3 - Outpatient Services Treated as Inpatient Services

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD -10, Implementation: ICD -10: Upon Implementation of ICD -10, ASC X12: September, 23 2014)

A. - Outpatient Services Followed by Admission Before Midnight of the Following Day (Effective For Services Furnished Before October 1, 1991)

When a beneficiary receives outpatient hospital services during the day immediately preceding the hospital admission, the outpatient hospital services are treated as inpatient services if the beneficiary has Part A coverage. Hospitals and *A/B MACs (A)* apply this provision only when the beneficiary is admitted to the hospital before midnight of the day following receipt of outpatient services. The day on which the patient is formally admitted as an inpatient is counted as the first inpatient day.

When this provision applies, services are included in the applicable PPS payment and not billed separately. When this provision applies to hospitals and units excluded from the hospital PPS, services are shown on the bill and included in the Part A payment. See Chapter 1 for *A/B MAC (A)* requirements for detecting duplicate claims in such cases.

B. - Preadmission Diagnostic Services (Effective for Services Furnished On or After January 1, 1991)

Diagnostic services (including clinical diagnostic laboratory tests) provided to a beneficiary by the admitting hospital, or by an entity wholly owned or wholly operated by the admitting hospital (or by another entity under arrangements with the admitting hospital), within 3 days prior to and including the date of the beneficiary's admission are deemed to be inpatient services and included in the inpatient payment, unless there is no Part A coverage. For example, if a patient is admitted on a Wednesday, outpatient services provided by the hospital on Sunday, Monday, Tuesday, or Wednesday are included in the inpatient Part A payment.

This provision does not apply to ambulance services and maintenance renal dialysis services (see the Medicare Benefit Policy Manual, Chapters 10 and 11, respectively). Additionally, Part A services furnished by skilled nursing facilities, home health agencies, and hospices are excluded from the payment window provisions.

For services provided before October 31, 1994, this provision applies to both hospitals subject to the hospital inpatient prospective payment system (IPPS) as well as those hospitals and units excluded from IPPS.

For services provided on or after October 31, 1994, for hospitals and units excluded from IPPS, this provision applies only to services furnished within one day prior to and including the date of the beneficiary's admission. The hospitals and units that are excluded from IPPS are: psychiatric hospitals and units; inpatient rehabilitation facilities (IRF) and units; long-term care hospitals (LTCH); children’s hospitals; and cancer hospitals.

The 3-day (or 1-day) payment window policy does not apply when the admitting hospital is a critical access hospital (CAH). Therefore outpatient diagnostic services rendered to a beneficiary by a CAH, or by an entity that is wholly owned or operated by a CAH, during the payment window, must not be bundled on the claim for the beneficiary's inpatient admission at the CAH. However, outpatient diagnostic services rendered to a beneficiary at a CAH that is wholly owned or operated by a non-CAH hospital, during the payment window, are subject to the 3-day (or 1-day) payment window policy.

The technical portion of any outpatient diagnostic service rendered to a beneficiary at a hospital-owned or hospital-operated physician clinic or practice during the payment window is subject to the 3-day (or 1-day) payment window policy (see MCPM, chapter 12, sections 90.7 and 90.7.1).

The 3-day (or 1-day) payment window policy does not apply to outpatient diagnostic services included in the rural health clinic (RHC) or Federally qualified health center (FQHC) all-inclusive rate (see MCPM, chapter 19, section 20.1).

Outpatient diagnostic services furnished to a beneficiary more than 3 days (for a non-subsection (d) hospital, more than 1 day) preceding the date of the beneficiary's admission to the hospital, by law, are not part of the payment window and must not be bundled on the inpatient bill with other outpatient services that were furnished during the span of the 3-day (or 1-day) payment window, even when all of the outpatient services were furnished during a single, continuous outpatient encounter. Instead, the outpatient diagnostic services that were furnished prior to the span of the payment window may be separately billed to Part B.

An entity is considered to be "wholly owned or operated" by the hospital if the hospital is the **sole** owner or operator. A hospital need not exercise administrative control over a facility in order to operate it. A hospital is considered the sole operator of the facility if the hospital has exclusive responsibility for implementing facility policies (i.e., conducting or overseeing the facility's routine operations), regardless of whether it also has the authority to make the policies.

For purposes of the 3-day (or 1-day) payment window policy, a "sponsorship" is treated the same as an "ownership", and a "non-profit" or "not-for-profit" entity is treated the same as a "for-profit" entity. Thus, outpatient diagnostic services provided by the admitting not-for-profit hospital, or by an entity that is wholly sponsored or operated by the admitting not-for-profit hospital, to a beneficiary during the 3 days (or 1 day) immediately preceding and including the date of the beneficiary's inpatient admission are deemed to be inpatient services and must be bundled on the claim for the beneficiary's inpatient stay at the not-for-profit hospital.

For this provision, diagnostic services are defined by the presence on the bill of the following revenue and/or CPT codes:

Code	**Description**
0254	Drugs incident to other diagnostic services
0255	Drugs incident to radiology
030X	Laboratory
031X	Laboratory pathological
032X	Radiology diagnostic
0341, 0343	Nuclear medicine, diagnostic/Diagnostic Radiopharmaceuticals
035X	CT scan
0371	Anesthesia incident to Radiology

Code	Description
0372	Anesthesia incident to other diagnostic services
040X	Other imaging services
046X	Pulmonary function
0471	Audiology diagnostic
0481, 0489	Cardiology, Cardiac Catheter Lab/Other Cardiology with CPT codes 93451-93464, 93503, 93505, 93530-93533, 93561-93568, 93571-93572, G0275, and G0278 diagnostic
0482	Cardiology, Stress Test
0483	Cardiology, Echocardiology
053X	Osteopathic services
061X	MRT
062X	Medical/surgical supplies, incident to radiology or other diagnostic services
073X	EKG/ECG
074X	EEG
0918-	Testing- Behavioral Health
092X	Other diagnostic services

The CWF rejects services furnished January 1, 1991, or later when outpatient bills for diagnostic services with through dates or last date of service (occurrence span code 72) fall on the day of admission or any of the 3 days immediately prior to admission to an IPPS or IPPS-excluded hospital. This reject applies to the bill in process, regardless of whether the outpatient or inpatient bill is processed first. Hospitals must analyze the two bills and report appropriate corrections. For services on or after October 31, 1994, for hospitals and units excluded from IPPS, CWF will reject outpatient diagnostic bills that occur on the day of or one day before admission. For IPPS hospitals, CWF will continue to reject outpatient diagnostic bills for services that occur on the day of or any of the 3 days prior to admission. Effective for dates of service on or after July 1, 2008, CWF will reject diagnostic services when the line item date of service (LIDOS) falls on the day of admission or any of the 3 days immediately prior to an admission to an IPPS hospital or on the day of admission or one day prior to admission for hospitals excluded from IPPS.

Hospitals in Maryland that are under the jurisdiction of the Health Services Cost Review Commission are subject to the 3-day payment window.

C. - Other Preadmission Services (Effective for Services Furnished On or After October 1, 1991 and Before June 25, 2010)

Nondiagnostic outpatient services that are related to a beneficiary's hospital admission and that are provided by the admitting hospital, or by an entity that is wholly owned or wholly operated by the admitting hospital (or by another entity under arrangements with the admitting hospital), to the patient during the 3 days immediately preceding and including the date of the beneficiary's admission are deemed to be inpatient services and are included in the inpatient payment. Effective March 13, 1998, we defined nondiagnostic preadmission services as being related to the admission only when there is an exact match (for all digits) between the principal diagnosis code assigned for both the preadmission services and the inpatient stay. Thus, whenever Part A covers an admission, the hospital may bill nondiagnostic preadmission services to Part B as outpatient services **only** if they are **not** related to the admission. The *A/B MAC (A)* shall assume,

in the absence of evidence to the contrary, that such bills are not admission related and, therefore, are not deemed to be inpatient (Part A) services. If there are both diagnostic and nondiagnostic preadmission services and the nondiagnostic services are unrelated to the admission, the hospital may separately bill the nondiagnostic preadmission services to Part B. This provision applies only when the beneficiary has Part A coverage. This provision does not apply to ambulance services and maintenance renal dialysis. Additionally, Part A services furnished by skilled nursing facilities, home health agencies, and hospices are excluded from the payment window provisions.

For services provided before October 31, 1994, this provision applies to both hospitals subject to IPPS as well as those hospitals and units excluded from IPPS (see section B above).

For services provided on or after October 31, 1994, for hospitals and units excluded from IPPS, this provision applies only to services furnished within one day prior to and including the date of the beneficiary's admission.

Hospitals must not include on a claim for an inpatient admission any outpatient nondiagnostic services that are not payable under Part B. For example, oral medications that are considered self-administered drugs under Part B are not payable under the outpatient prospective payment system (OPPS) and must not be bundled on an inpatient claim for purposes of the 3-day (or 1-day) payment window policy.

The 3-day (or 1-day) payment window policy does not apply when the admitting hospital is a critical access hospital (CAH). Therefore, outpatient nondiagnostic services rendered to a beneficiary by a CAH, or by an entity that is wholly owned or operated by a CAH, during the payment window, must <u>not</u> be bundled on the claim for the beneficiary's inpatient admission at the CAH. However, admission-related outpatient nondiagnostic services rendered to a beneficiary at a CAH that is wholly owned or operated by a non-CAH hospital, during the payment window, are subject to the 3-day (or 1-day) payment window policy.

The technical portion of any admission-related outpatient nondiagnostic service rendered to a beneficiary at a hospital-owned or hospital-operated physician clinic or practice during the payment window is subject to the 3-day (or 1-day) payment window policy (see MCPM, chapter 12, sections 90.7 and 90.7.1).

The 3-day (or 1-day) payment window policy does not apply to outpatient nondiagnostic services that are included in the rural health clinic (RHC) or Federally qualified health center (FQHC) all-inclusive rate (see MCPM, chapter 19, section 20.1).

Outpatient nondiagnostic services furnished to a beneficiary more than 3 days (for a non-subsection (d) hospital, more than 1 day) preceding the date of the beneficiary's admission to the hospital, by law, are not part of the payment window and must not be bundled on the inpatient bill with other outpatient services that were furnished during the span of the 3-day (or 1-day) payment window, even when all of the outpatient services were furnished during a single, continuous outpatient encounter. Instead, the outpatient nondiagnostic services that were furnished prior to the span of the payment window may be separately billed to Part B.

An entity is considered to be "wholly owned or operated" by the hospital if the hospital is the **sole** owner or operator. A hospital need not exercise administrative control over a facility in order to operate it. A hospital is considered the sole operator of the facility if the hospital has exclusive responsibility for implementing facility policies (i.e., conducting or overseeing the facility's routine operations), regardless of whether it also has the authority to make the policies.

For purposes of the 3-day (or 1-day) payment window policy, a "sponsorship" is treated the same as an "ownership", and a "non-profit" or "not-for-profit" entity is treated the same as a "for-profit" entity. Thus, admission-related outpatient nondiagnostic services provided by the admitting not-for-profit hospital, or by an entity that is wholly sponsored or operated by the admitting not-for-profit hospital, to a beneficiary during the 3 days (or 1 day) immediately preceding and including the date of the beneficiary's inpatient

admission are deemed to be inpatient services and must be bundled on the claim for the beneficiary's inpatient stay at the not-for-profit hospital.

Hospitals in Maryland that are under the jurisdiction of the Health Services Cost Review Commission are subject to the 3-day payment window.

Effective for dates of service on or after July 1, 2008 and before June 25, 2010, CWF will reject claims for nondiagnostic services when the following is met:

1) There is an exact match (for all digits) between the principal diagnosis code assigned for both the preadmission services and the inpatient stay, and

2) The line item date of service (LIDOS) falls on the day of admission or any of the 3 days immediately prior to an admission to an IPPS hospital (or on the day of admission or one day prior to admission for hospitals excluded from IPPS).

D - Other Preadmission Services (Effective for Services Furnished On or After June 25, 2010)

Beginning on or after June 25, 2010, the definition of "other services related to the admission" (i.e., admission-related outpatient "nondiagnostic" services) is revised for purposes of the 3-day (or 1-day) payment window policy. Except for the following changes, the other requirements in section 40.3.C continue to be applicable.

For outpatient nondiagnostic services furnished on or after June 25, 2010, all outpatient nondiagnostic services, other than ambulance and maintenance renal dialysis services, provided by the hospital (or an entity wholly owned or wholly operated by the hospital) on the date of a beneficiary's inpatient admission are deemed related to the admission, and thus, must be billed with the inpatient stay. Also, outpatient nondiagnostic services, other than ambulance and maintenance renal dialysis services, provided by the hospital (or an entity wholly owned or wholly operated by the hospital) on the first, second, and third calendar days for a subsection (d) hospital paid under the IPPS (first calendar day for non-subsection (d) hospitals) preceding the date of a beneficiary's inpatient admission are deemed related to the admission, and thus, must be billed with the inpatient stay, unless the hospital attests to specific nondiagnostic services as being unrelated to the hospital claim (that is, the preadmission nondiagnostic services are clinically distinct or independent from the reason for the beneficiary's admission) by adding a condition code 51 (definition "51 - Attestation of Unrelated Outpatient Non-diagnostic Services") to the separately billed outpatient non-diagnostic services claim. Beginning on or after April 1, 2011, providers may submit outpatient claims with condition code 51 for outpatient claims that have a date of service on or after June 25, 2010.

Hospitals must include on a Medicare claim for a beneficiary's inpatient stay the diagnoses, procedures, and charges for all preadmission outpatient diagnostic services and all preadmission outpatient nondiagnostic services that meet the above requirements. For purposes of the Present on Admission Indicator (POA), even if the outpatient services are bundled with the inpatient claim, hospitals shall code any conditions the patient has at the time of the order to admit as an inpatient as POA irrespective of whether or not the patient had the condition at the time of being registered as a hospital outpatient. In combining on the inpatient bill the diagnoses, procedures, and charges for the outpatient services, a hospital must convert CPT codes to ICD *procedure* codes and must only include outpatient diagnostic and admission-related nondiagnostic services that span the period of the payment window.

Outpatient nondiagnostic services provided during the payment window that are unrelated to the admission and are covered by Part B may be separately billed to Part B. Hospitals must maintain documentation in the beneficiary's medical record to support their claim that the preadmission outpatient nondiagnostic services are unrelated to the beneficiary's inpatient admission.

Effective for dates of service on or after June 25, 2010, CWF will reject outpatient claims for nondiagnostic services when the following occurs:

1) Condition code 51 (definition “51 - Attestation of Unrelated Outpatient Non-diagnostic Services”) is not included on the outpatient claim, and

2) The line item date of service (LIDOS) falls on the day of admission or any of the 3 days immediately prior to an admission to an IPPS hospital (or on the day of admission or one day prior to admission for hospitals excluded from IPPS).

50 - Adjustment Bills

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD -10, Implementation: ICD -10: Upon Implementation of ICD -10, ASC X12: September, 23 2014)

Adjustment bills are the most common mechanism for changing a previously accepted bill. They are required to reflect the results of A/B MAC *(A)'s* 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 *A/B MAC (A)* 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 *A/B MAC (A)* 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 *A/B MAC (A)* 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 *on* the *Form* CMS-1450 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 *A/B MAC (A)* initiates), the *A/B MAC (A)* submits an adjustment bill to CWF following its acceptance of the initial bill. To verify CMS' acceptance, it *takes one* 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:

- *A/B MAC (A)* control number (ICN/DCN);

- Surname;
- HICN;

When a definite match cannot be made on the 3 fields above, the provider's *A/B MAC (A)* 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 *A/B MAC (A)* either electronically or on hard copy. Electronic submission is preferred.

The *A/B MAC (A)* 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	*A/B MAC (A)*
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 *A/B MAC (A)* 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 *A/B MAC (A)* receives a CWF alert or a CMS-L1002.

The *A/B MAC (A)* prepares an adjustment if instructed by CO or RO to make a change. Typically, the *A/B MAC (A)* 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 *A/B MAC (A)* to correct it.

If the *A/B MAC (A)* furnished the *A/B MAC (B)* 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 *A/B MAC (A)* must submit the adjustment bill in its CWF record. If a rejected adjustment bill is determined to be unnecessary, the *A/B MAC (A)* stops the adjustment action upon receipt of correction.

Where an adjustment bill changes subsequent utilization, the *A/B MAC (A)* notes this and processes adjustments to subsequent bills if it services the provider.

If the *A/B MAC (A)* does not service the provider, CMS will contact the *A/B MACs (A)*, 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 *A/B MAC (A)* 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 *A/B MAC (A)* 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 *A/B MAC (A)* 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 *A/B MAC (A)* 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 *A/B MAC (A)* 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.

50.1 - Tolerance Guidelines for Submitting Adjustment Requests

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD -10, Implementation: ICD -10: Upon Implementation of ICD -10, ASC X12: September, 23 2014)

When a bill is submitted and the hospital or the *A/B MAC (A)* discovers an error, the hospital submits an adjustment request using the *ASC X12 837 institutional claim format or the* Form CMS-1450, if the error is a change in the:

- Number of inpatient days (including a change in the length of stay, or a different allocation of covered/non-covered days;
- Blood deductible;
- Inpatient cash deductible of more than $1;
- Servicing provider;
- Discharge status in a PPS hospital;
- Diagnosis or Procedures that impact the assigned DRG code; or
- Outlier payment amount.

The provider submits most adjustment requests as debits, using bill type XX7.

Also, it submits a debit-only adjustment request to the *A/B MAC (A)* if the hospital previously submitted an interim bill for a PPS hospital stay or wishes to change the number of days in any inpatient stay.

The *A/B MAC (A)* then submits the adjustment to CWF. An adjustment from the QIO for any of the above also requires a submission to CMS via CWF.

If PPS is involved and the DRG has been changed as a result of medical review after an original bill has been forwarded to CMS, adjustment debit/credit bills are required. The corrected bill must be an exact duplicate of the original, except for any changed fields including diagnostic and procedure codes.

50.2 - Claim Change Reasons

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD -10, Implementation: ICD -10: Upon Implementation of ICD -10, ASC X12: September, 23 2014)

A. - Claim Change Reason Codes

The provider submits one of the following claim change reason codes to its *A/B MAC (A)* with each debit-only or cancel-only adjustment request:

Bill Type	Reason Code	Explanation
XX7	D0 (zero)	Change to service dates
XX7	D1	Change in charges
XX7	D2	Change in revenue codes/HCPCS
XX7	D3	Second or subsequent interim PPS bill - inpatient only
XX7	D4	Change in GROUPER input (diagnoses or procedures) - inpatient only
XX8	D5	Cancel-only to correct a HICN or provider identification number
XX8	D6	Cancel-only to repay a duplicate payment or OIG overpayment (includes cancellation of an outpatient bill containing services required to be included on the inpatient bill.)
XX7	D7	Change to make Medicare the secondary payer

Bill Type	Reason Code	Explanation
XX7	D8	Change to make Medicare the primary payer
XX7	D9	Any other change
XX7	E0 (zero)	Change in patient status

The provider may not submit more than one claim change reason code per adjustment request. It must choose the single reason that best describes the adjustment it is requesting. It should use claim change reason code D1 only when the charges are the only change on the claim. Other claim change reasons frequently change charges, but the provider may not "add" reason code D1 when this occurs.

The claim change reason code is entered as a condition code on the *ASC X12 837 institutional claim format or on the* hard copy Form CMS-1450 For reason codes D0-D4 and D7-D9, submit a debit-only adjustment request, bill type XX7. For reason codes D5 and D6, submit a cancel-only adjustment request, bill type XX8.

B. - Edits on Claim Change Reason Codes

The following edits are based on the claim change reason code. The *A/B MAC (A)* must apply them to each incoming adjustment request.

- If the type of bill is equal to XX7 and the claim change reason code is not equal to D0-D4, D7-D9, or E0, the *A/B MAC (A)* rejects the request back to the provider with the following error message, "Claim change reason code must be present and equal to D0-D4, D7-D9, or E0 for a debit-only adjustment request."

- If the type of bill is equal to XX8 and the claim change reason code is not equal to D5-D6, the *A/B MAC (A)* rejects the request back to the provider with the following error message, "Claim change reason code must be present and equal to D5-D6 for a cancel-only adjustment request."

- If the type of bill is equal to XX7 or XX8 and the ICN/DCN of the claim being adjusted is not present, the *A/B MAC (A)* rejects the request back to the provider with the following message, "ICN/DCN of the claim being adjusted is required for an adjustment request."

- If more than one claim change reason code is present on the provider's request, the *A/B MAC (A)* rejects the request back to the provider with the following message, "only one claim change reason code may apply to a single adjustment request from a provider. Choose the single claim change reason code that best describes the reason for the provider's request and resubmit."

- If the provider submits an adjustment request as type of bill not equal to XX7 or XX8, the *A/B MAC (A)* rejects the request back to the provider with the message, "Provider submitted adjustment request must use type of bill equal to XX7 or XX8."

- If the claim change reason code is equal to D0, the *A/B MAC (A)* compares the beginning and ending dates on the provider's request to those on the claim to be adjusted on its history. If these dates are the same, it rejects the request back to the provider with the message, "Dates of service must change for claim change reason code D0."

- If the claim change reason code is equal to D1, the *A/B MAC (A)* compares the total and line item charges on the provider's request to those on the claim to be adjusted on its history. If these changes are the same, the *A/B MAC (A)* rejects the request back to the provider with the message, "Charges must be changed for claim change reason code D1."

- If the claim change reason code is equal to D2, the *A/B MAC (A)* compares revenue codes/HCPCS on the provider's request to those on the claim to be adjusted on its history. If these codes are the same, it rejects the request back to the provider with the message, "Revenue codes/HCPCS must change for claim change reason code D2."

- If the claim change reason code is equal to D3, the *A/B MAC (A)* compares the ending date on the provider's request to that on the claim to be adjusted on its history. If these dates are the same, it rejects the request back to the provider with the message, "Thru dates must change for the claim change reason code D3."

- If the claim change reason code is equal to D4, the *A/B MAC (A)* compares diagnosis and procedure codes on the provider's request to those on the claim to be adjusted on its history. If these codes are the same and are in the same sequence, it rejects the request back to the provider with the message, "Diagnoses and/or procedures must change for claim change reason code D4."

- If the claim change reason code is equal to D5 or D6, type of bill must be equal to XX8 on the provider's request. If type of bill is not equal to XX8, the *A/B MAC (A)* rejects the request back to the provider with the message, "Type of bill must be equal to XX8 for claim change reason codes D5 or D6."

- If the claim change reason code is equal to D7, an MSP value code (12-16, 41-43, or 47) must be present, if a value code, 12-16, 41-43, or 47, is not present, the *A/B MAC (A)* rejects the request back to the provider with the message, "An MSP value code (12-16, 41-43, or 47) must be present for claim change reason code D7."

- If the claim change reason code is equal to D7, and one or more of value codes 12-16, 41-43, and/or 47 is present but each value amount is equal to 0 (zero) or spaces, the *A/B MAC (A)* rejects the request back to the provider with the message, "invalid value amount for claim change reason code D7."

- If the claim change reason code is equal to D8, and a value code 12-16, 41-43, or 47 is present, the *A/B MAC (A)* rejects the claim back to the provider with the message, "Invalid value code for claim change reason D8."

- If the claim change reason code is equal to E0, the *A/B MAC (A)* compares patient status on the provider's request to that on the claim to be adjusted. If patient status is the same, the *A/B MAC (A)* rejects the request back to the provider with the message, "Patient status must change for claim change reason E0."

If an adjustment the provider initiates results in a change to a higher weighted DRG, the *A/B MAC (A)* edits the adjustment request to insure it was submitted within 60 days of the date of the remittance for the claim to be adjusted. If it is, the *A/B MAC (A)* processes the claim for payment. If the remittance date is more than 60 days prior to the receipt date of the adjustment request and results in a change to a lower weighted DRG, the *A/B MAC (A)* processes the claim for payment and forwards it to CWF.

The *A/B MAC (A)* must suspend for investigation all adjustment requests with claim change reason codes D4, D8, and D9. Providers that consistently use D9 will be investigated and, if a pattern of abuse is evident, may be reported to the OIG.

C. - Additional edits

The *A/B MAC (A)* must perform the following additional edits and investigate adjustment requests the provider submits:

- A full denial once the bill is paid, except to accomplish retraction of a duplicate payment;

- A change in DRG based on a change in age or sex;
- A change in deductible;
- An adjustment request that changes a previously submitted QIO adjustment request;
- An adjustment of a bill due to a change in utilization or spell data on another bill;
- A reopening to change a no-payment bill to a payment bill;
- A reopening to pay a previously denied line item;
- An adjustment request the provider initiates with a claim change reason code equal to D7, with the Medicare payment amount equal to or greater that the previously paid amount; or
- An adjustment request with a claim change reason code equal to E0, and the claim is for a PPS provider. The *A/B MAC (A)* must investigate if the change is from patient status 02, transferred to another acute care facility.

60 - Swing-Bed Services

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD -10, Implementation: ICD -10: Upon Implementation of ICD -10, ASC X12: September, 23 2014)

Swing-bed services must be billed separately from inpatient hospital services. Swing-bed hospitals use one provider number when billing for hospital services to identify hospital swing-bed SNF bills. The following alpha letters identify hospital swing-bed SNF bills (for CMS use only, effective May 23, 2007, providers are required to submit only their NPI. NOTE: The swing-bed NPI will be mapped to the 6-digit alpha-numeric legacy (OSCAR) number.):

- "U" = short-term/acute care hospital swing-bed;
- "W" = long-term hospital swing-bed*;*
- "Y" = rehabilitation hospital swing-bed*; and*
- *"Z"=CAH swing-bed*.

A. - Inpatient Hospital Services in a Swing-Bed

The patient status code of 03 is inserted on the claim when the beneficiary swings from acute to SNF level of care. (This constitutes a discharge for purposes of Medicare payment for inpatient hospital services under PPS.) The *A/B MAC (A)* indicates in *the Statement Covers Through Date* the last day of care at the hospital level.

If the beneficiary is discharged from a Medicare swing bed and remains in the hospital, there is no need for a no-pay bill. However, if a beneficiary continues to receive care after completing their stay in a SNF swing bed, in a NF swing bed, the hospital must submit covered claims to Medicare.

B. - SNF Services in a Swing-Bed

Services are billed, in accordance with Chapter 25 with the following exceptions:

- The date of admission on the swing-bed SNF bill is the date the patient began to receive SNF level of care services;
- State level agreements may call for varying types of bill coding Type of Bill. The CMS does not perform edits on type of bill coding on bills with 8 in the 2nd digit (bill classification), in FL 18 of

the CWF inpatient record if the record is identified in FL 1 as hospital or SNF. Therefore, the *A/B MAC (A)* accepts, with subsequent conversion, any bill type agreed to at the State level to identify swing-bed billing, i.e., 18X or 21X. It must be sure the record identification of CWF FL 1 is consistent with the provider number shown.

70.1 - Providers Using All-Inclusive Rates for Inpatient Part A Charges

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Some providers have been approved to bill a flat fee charge for inpatient services based on either a daily basis or total stay basis for services furnished. This is an "All-Inclusive Rate." These charges may cover room and board, including ancillary services, or room and board only. These instructions explain the essential data entries that must be made *using the ASC X12 837 institutional claim format or* on the Form CMS-1450 by providers that use all-inclusive rates as charges. All-inclusive rate providers are identified by one of the following charge structures:

- One total all-inclusive charge rate for both accommodations and ancillary services, including the cost of blood in the rate;
- One total all-inclusive charge rate for both accommodations and ancillary services, not including the cost of blood in the rate;
- One all-inclusive charge rate for accommodations and another for ancillary services, including the cost of blood in the all-inclusive rate; or
- One all-inclusive charge rate for accommodations and another for ancillary services, not including the cost of blood in the all-inclusive rate.

Providers follow these special instructions for completing of the billing *format or form.*

A. - Accommodations

Revenue Codes - Codes that identify the accommodations furnished, ancillary services provided or billing calculation are entered in *this field*. The code indicates whether the rate includes charges for ancillary services or only room and board.

If the patient was furnished more than one type of accommodation, the *loops or* lines for each type of accommodation are completed. This is necessary whether or not the provider charges an all-inclusive rate according to accommodations.

Where the all-inclusive rate varies with the type of accommodation, *the Remarks field* is annotated for a five-or-more bed accommodation showing the reason for the accommodation.

Unit of Service - A quantitative measure for services furnished, by revenue category, to or for the patient which includes items such as the number of accommodation days, pints of blood, or renal dialysis treatments, is entered.

Total Charges - The total charges pertaining to the related revenue code for the current billing period is entered.

Noncovered Charges - The total non-covered charges pertaining to the related revenue code for the current billing period is entered.

B. - Ancillary Services

One All-Inclusive Charge Rate - Hospitals with one all-inclusive charge rate, including ancillary services, are reflected in the revenue code. The total charge reflects the charge for both accommodations and ancillary services.

Separate Ancillary All-Inclusive Rate - Some providers segregate charges for ancillary services for billing purposes. Where a separate flat rate charge for ancillary services is incurred either on a daily or total stay basis, the provider enters separate codes for the services. These codes indicate whether the total charge includes only ancillary cost or includes other costs (i.e., blood).

If applicable, the following additional billing instructions are applied:

- Blood

  Whenever whole blood is furnished the patient, *value codes and amounts* are completed. If the all-inclusive rate does not include the charge for whole blood or packed cells, revenue codes, rates, service dates, units, and total charges are completed in the same way a provider not using all-inclusive rates would complete them. When the provider discounts its customary charges for unreplaced blood to which the deductible is applicable, it shows the charges before the discount.

  If the all-inclusive rate covers the cost of providing blood whenever a patient needs it, the number of pints furnished, replaced, not replaced, and the estimated cost per pint is entered in *value codes and amounts*. No amount can be shown in the Total Charges column since the rate includes the cost of blood. It is not necessary to show the cost for any replaced blood.

- All-Inclusive Charges According to Disease, Injury, or Type of Treatment

  Providers that have a charge system based on the patient's illness or injury or type of treatment complete the *applicable loops or* line(s) for type of accommodation furnished showing number of days, rate, and total charges. The rate amount and total amounts must be the same. Blood entries are indicated as above.

- Physician's Component

  As with providers having a schedule of charges for individual services, the amount of any physician's component included in the all-inclusive charge is removed from the total covered charges before applying the inpatient deductible or coinsurance.

- Combined Billing

  CMS does not encourage the all-inclusive rate provider to combine bill. However, if it does, it must develop the capability and indicate in *the* Remarks *field*, the number and type of each service it is combined billing. To identify such cases, the remark "Combined Billing" must be written in *the* Remarks *field*.
  NOTE: Combined billing was eliminated with Outpatient PPS.

90.1.1 - The Standard Kidney Acquisition Charge

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD -10, Implementation: ICD -10: Upon Implementation of ICD -10, ASC X12: September, 23 2014)

There are two basic standard charges that must be developed by transplant hospitals from costs expected to be incurred in the acquisition of kidneys:

- The standard charge for acquiring a live donor kidney; and

- The standard charge for acquiring a cadaver kidney.

The standard charge is not a charge representing the acquisition cost of a specific kidney; rather, it is a charge that reflects the average cost associated with each type of kidney acquisition.

When the transplant hospital bills the program for the transplant, it shows its standard kidney acquisition charge on revenue code 081X. *Kidney acquisition charges* are not considered for the IPPS outlier calculation.

Acquisition services are billed from the excising hospital to the transplant hospital. A billing form is not submitted from the excising hospital to the FI. The transplant hospital keeps an itemized statement that identifies the services furnished, the charges, the person receiving the service (donor/recipient), and whether this is a potential transplant donor or recipient. These charges are reflected in the transplant hospital's kidney acquisition cost center and are used in determining the hospital's standard charge for acquiring a live donor's kidney or a cadaver's kidney. The standard charge is not a charge representing the acquisition cost of a specific kidney. Rather, it is a charge that reflects the average cost associated with each type of kidney acquisition. Also, it is an all-inclusive charge for all services required in acquisition of a kidney, i.e., tissue typing, post-operative evaluation.

A. - Billing For Blood And Tissue Typing of the Transplant Recipient Whether or Not Medicare Entitlement Is Established

Tissue typing and pre-transplant evaluation can be reflected only through the kidney acquisition charge of the hospital where the transplant will take place. The transplant hospital includes in its kidney acquisition cost center the reasonable charges it pays to the independent laboratory or other hospital which typed the potential transplant recipient, either before or after his entitlement. It also includes reasonable charges paid for physician tissue typing services, applicable to live donors and recipients (during the pre-entitlement period and after entitlement, but prior to hospital admission for transplantation).

B. - Billing for Blood and Tissue Typing and Other Pre-Transplant Evaluation of Live Donors

The entitlement date of the beneficiary who will receive the transplant is not a consideration in reimbursing for the services to donors, since no bill is submitted directly to Medicare. All charges for services to donors prior to admission into the hospital for excision are "billed" indirectly to Medicare through the live donor acquisition charge of transplanting hospitals.

C. - Billing Donor And Recipient Pre-Transplant Services (Performed by Transplant Hospitals or Other Providers) to the Kidney Acquisition Cost Center

The transplant hospital prepares an itemized statement of the services rendered for submittal to its cost accounting department. Regular Medicare billing forms are not necessary for this purpose, since no bills are submitted to the *A/B MAC (A)* at this point.

The itemized statement should contain information that identifies the person receiving the service (donor/recipient), the health care insurance number, the service rendered and the charge for the service, as well as a statement as to whether this is a potential transplant donor or recipient. If it is a potential donor, the provider must identify the prospective recipient.

EXAMPLE:

Mary Jones
Health care insurance number
200 Adams St.
Anywhere, MS

Transplant donor evaluation services for recipient:

John Jones
Health care insurance number
200 Adams St.
Anywhere, MS

Services performed in a hospital other than the potential transplant hospital or by an independent laboratory are billed by that facility to the potential transplant hospital. This holds true regardless of where in the United States the service is performed. For example, if the donor services are performed in a Florida hospital and the transplant is to take place in a California hospital, the Florida hospital bills the California hospital (as described in above). The Florida hospital is paid by the California hospital, which recoups the monies through the kidney acquisition cost center.

D. - Billing for Cadaveric Donor Services

Normally, various tests are performed to determine the type and suitability of a cadaver kidney. Such tests may be performed by the excising hospital (which may also be a transplant hospital) or an independent laboratory. When the excising-only hospital performs the tests, it includes the related charges on its bill to the transplant hospital or to the organ procurement agency.

When the tests are performed by the transplant hospital, it uses the related costs in establishing the standard charge for acquiring the cadaver kidney. The transplant hospital includes the costs and charges in the appropriate departments for final cost settlement purposes.

When the tests are performed by an independent laboratory for the excising-only hospital or the transplant hospital, the laboratory bills the hospital that engages its services or the organ procurement agency. The excising-only hospital includes such charges in its charges to the transplant hospital, which then includes the charges in developing its standard charge for acquiring the cadaver kidney. It is the transplant hospitals' responsibility to assure that the independent laboratory does not bill both hospitals.

The cost of these services cannot be billed directly to the program, since such tests and other procedures performed on a cadaver are not identifiable to a specific patient.

E. - Billing For Physicians' Services Prior to Transplantation

Physicians' services applicable to kidney excisions involving live donors and recipients (during the pre-entitlement period and after entitlement, but prior to entrance into the hospital for transplantation) as well as all physicians' services applicable to cadavers are considered Part A hospital services (kidney acquisition costs).

F. - Billing for Physicians' Services After Transplantation

All physicians' services rendered to the living donor and all physicians' services rendered to the transplant recipient are billed to the Medicare program in the same manner as all Medicare Part B services are billed. All donor physicians' services must be billed to the account of the recipient (i.e., the recipient's Medicare number). Modifier Q3 (Live Kidney Donor and Related Services) appears on the claim. For services performed on or after January 1, 2011 CWF shall allow Edit 5211 to be overridden at the contractor level. Also, contractors shall override Edit 5211 when this modifier appears on claims for donor services it receives when the recipient is deceased (See Publication 100-02, Chapter 11, Section 80.4).

NOTE: For institutional claims, contractors may manually override the CWF edit as necessary.

G. - Billing For Physicians' Renal Transplantation Services

To ensure proper payment when submitting a Part B bill for the renal surgeon's services to the recipient, the appropriate HCPCS codes must be submitted, including HCPCS codes for concurrent surgery, as applicable.

The bill must include all living donor physicians' services, e.g., Revenue Center code 081X.

90.1.2 - Billing for Kidney Transplant and Acquisition Services

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD -10, Implementation: ICD -10: Upon Implementation of ICD -10, ASC X12: September, 23 2014)

Applicable standard kidney acquisition charges are identified separately by revenue code 0811 (Living Donor Kidney Acquisition) or 0812 (Cadaver Donor Kidney Acquisition). 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 charges for services rendered directly to the Medicare recipient.

The contractor deducts kidney acquisition charges for PPS hospitals for processing through Pricer. These costs, incurred by approved kidney transplant hospitals, are **not** included in the kidney transplant prospective payment. They are paid on a reasonable cost basis. Interim payment is paid as a "pass through" item. (See the Provider Reimbursement Manual, Part 1, §2802 B.8.) The contractor includes kidney acquisition charges under the appropriate revenue code in CWF.

Bill Review Procedures

The Medicare Code Editor (MCE) creates a Limited Coverage edit for *kidney transplant procedure codes*. Where *these* procedure code*s are* identified by MCE, the contractor checks the provider number to determine if the provider is an approved transplant center, and checks the effective approval date. The contractor shall also determine if the facility is certified for adults and/or pediatric transplants dependent upon the patient's age. If payment is appropriate (i.e., the center is approved and the service is on or after the approval date) it overrides the limited coverage edit.

90.2 - Heart Transplants

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD -10, Implementation: ICD -10: Upon Implementation of ICD -10, ASC X12: September, 23 2014)

Cardiac transplantation is covered under Medicare when performed in a facility which is approved by Medicare as meeting institutional coverage criteria. On April 6, 1987, CMS Ruling 87-1, "Criteria for Medicare Coverage of Heart Transplants" was published in the "Federal Register." For Medicare coverage purposes, heart transplants are medically reasonable and necessary when performed in facilities that meet these criteria. If a hospital wishes to bill Medicare for heart transplants, it must submit an application and documentation, showing its ongoing compliance with each criterion.

If a contractor has any questions concerning the effective or approval dates of its hospitals, it should contact its RO.

For a complete list of approved transplant centers, visit:
https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/downloads/ApprovedTransplantPrograms.pdf

A. - Effective Dates

The effective date of coverage for heart transplants performed at facilities applying after July 6, 1987, is the date the facility receives approval as a heart transplant facility. Coverage is effective for discharges October 17, 1986 for facilities that would have qualified and that applied by July 6, 1987. All transplant hospitals will be recertified under the final rule, **Federal Register** / Vol. 72, No. 61 / Friday, March 30, 2007, / Rules and Regulations.

The CMS informs each hospital of its effective date in an approval letter.

B. - Drugs

Medicare Part B covers immunosuppressive drugs following a covered transplant in an approved facility.

C. - Noncovered Transplants

Medicare will **not** cover transplants or re-transplants in facilities that have not been approved as meeting the facility criteria. If a beneficiary is admitted for and receives a heart transplant from a hospital that is not approved, physicians' services, and inpatient services associated with the transplantation procedure are not covered.

If a beneficiary received a heart transplant from a hospital while it was not an approved facility and later requires services as a result of the noncovered transplant, the services are covered when they are reasonable and necessary in all other respects.

D. - Charges for Heart Acquisition Services

The excising hospital bills the OPO, who in turn bills the transplant (implant) hospital for applicable services. It should not submit a bill to its contractor. The transplant hospital must keep an itemized statement that identifies the services rendered, the charges, the person receiving the service (donor/recipient), and whether this person is a potential transplant donor or recipient. These charges are reflected in the transplant hospital's heart acquisition cost center and are used in determining its standard charge for acquiring a donor's heart. The standard charge is not a charge representing the acquisition cost of a specific heart; rather, it reflects the average cost associated with each type of heart acquisition. Also, it is an all inclusive charge for all services required in acquisition of a heart, i.e., tissue typing, post-operative evaluation, etc.

Acquisition charges shall be billed on a 081X revenue code. Such charges are not considered for the IPPS outlier calculation when billed for a heart transplant.

E. - Bill Review Procedures

The contractor takes the following actions to process heart transplant bills. It may accomplish them manually or modify its MCE and Grouper interface programs to handle the processing.

1. - MCE Interface

The MCE creates a Limited Coverage edit for *heart transplant procedure codes.* Where *these* procedure code*s are* identified by MCE, the contractor checks the provider number to determine if the provider is an approved transplant center, and checks the effective approval date. The contractor shall also determine if the facility is certified for adults and/or pediatric transplants dependent upon the patient’s age. If payment is appropriate (i.e., the center is approved and the service is on or after the approval date) it overrides the limited coverage edit.

2. - Handling Heart Transplant Billings From Nonapproved Hospitals

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

90.2.1 - Artificial Hearts and Related Devices

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD -10, Implementation: ICD -10: Upon Implementation of ICD -10, ASC X12: September, 23 2014)

Effective for discharges before May 1, 2008, Medicare does not cover the use of artificial hearts, either as a permanent replacement for a human heart or as a temporary life-support system until a human heart becomes available for transplant (often referred to a "bridge to transplant").

Medicare does cover a Ventricular Assist Device (VAD). A VAD is used to assist a damaged or weakened heart in pumping blood. VADs are used as a bridge to a heart transplant, for support of blood circulation postcardiotomy or destination therapy. Refer to the NCD Manual, section 20.9 for coverage criteria.

The MCE creates a Limited Coverage edit for “heart assist device” procedures. *These* procedure code*s have* limited coverage due to the stringent conditions that must be met by hospitals. Where procedure code*s are* identified by MCE, the *A/B MAC (A)* shall determine if coverage criteria is met and override the MCE if appropriate.

Effective for discharges on or after May 1, 2008, the use of artificial hearts will be covered by Medicare under Coverage with Evidence Development when beneficiaries are enrolled in a clinical study that meets all of the criteria listed in Pub. 100-03, Medicare NCD Manual, section 20.9.

90.3 - Stem Cell Transplantation

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD -10, Implementation: ICD -10: Upon Implementation of ICD -10, ASC X12: September, 23 2014)

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 *A/B MAC (A)*'s Medicare Code Editor (MCE) will edit stem cell transplant procedure codes 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.

Bone marrow transplant codes that are reported with an ICD-9-CM that is “not otherwise specified” are returned to the hospital for a more specific procedure code. ICD-10-PCS codes are more precise and clearly identify autologous and nonautologous stem cells.

The *A/B MAC (A)* may choose to review if data analysis deems it a priority.

90.3.1 - Allogeneic Stem Cell Transplantation

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD -10, Implementation: ICD -10: Upon Implementation of ICD -10, ASC X12: September, 23 2014)

A. - General

Allogeneic stem cell transplantation is a procedure in which a portion of a healthy donor's stem cells are obtained and prepared for intravenous infusion to restore normal hematopoietic function in recipients having an inherited or acquired hematopoietic deficiency or defect. See Pub. 100-03, National Coverage Determinations Manual, chapter 1, section 110.8.1, for more information.

Expenses incurred by a donor are a covered benefit to the recipient/beneficiary but, except for physician services, are not paid separately. Services to the donor include physician services, hospital care in connection with screening the stem cell, and ordinary follow-up care.

B. - Covered Conditions

1. - Effective for services performed on or after August 1, 1978:

For the treatment of leukemia, leukemia in remission, and aplastic anemia when it is reasonable and necessary; and

2. - Effective for services performed on or after June 3, 1985:

For the treatment of severe combined immunodeficiency disease (SCID), and for the treatment of Wiskott-Aldrich syndrome.

C. - Non-Covered Conditions

***1.* - Effective for services performed on or after May 24, 1996:**

Allogeneic stem cell transplantation is not covered as treatment for multiple myeloma.

***2.* - Effective for services performed on or after August 4, 2010:**

The Centers for Medicare & Medicaid Services (CMS) issued an NCD stating that it believes the evidence does not demonstrate that the use of allogeneic hematopoietic stem cell transplantation (HSCT) improves health outcomes in Medicare beneficiaries with Myelodysplastic Syndrome (MDS). Therefore, allogeneic HSCT for MDS is not reasonable and necessary under §1862(a)(1)(A) of the Social Security Act (the Act).

However, allogeneic HSCT for MDS is reasonable and necessary under §1862(a)(1)(E) of the Act and therefore covered by Medicare ONLY if provided pursuant to a Medicare-approved clinical study under Coverage with Evidence Development (CED). These services are covered in both the inpatient and outpatient hospital setting. Refer to Pub. 100-03, NCD Manual, chapter 1, section 110.8.1, for further information about this policy, and Pub. 100-04, MCP Manual, chapter 32, section 90.6, for information on CED.

For inpatient hospital claims, TOB 11x, if ICD-9-CM is applicable, diagnoses are 238.75 and V70.7. If ICD-10-CM is applicable, the diagnosis codes are D46.9, D46.Z, and Z00.6

NOTE: Coverage for conditions other than these specifically designated as covered or non-covered in the CP or NCD Manuals are left to local Medicare contractor discretion.

90.3.2 - Autologous Stem Cell Transplantation (AuSCT)

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD -10, Implementation: ICD -10: Upon Implementation of ICD -10, ASC X12: September, 23 2014)

A. - General

Autologous stem cell transplantation (AuSCT) is a technique for restoring stem cells using the patient's own previously stored cells. AuSCT must be used to effect hematopoietic reconstitution following severely

myelotoxic doses of chemotherapy (high dose chemotherapy (HDCT)) and/or radiotherapy used to treat various malignancies.

If ICD-9-CM is applicable, use the following Procedure Codes and Descriptions

ICD-9-CM Code	***Description***
41.01	*Autologous bone marrow transplant without purging*
41.04	*Autologous hematopoietic stem cell transplant without purging*
41.07	*Autologous hematopoietic stem cell transplant with purging*
41.09	*Autologous bone marrow transplant with purging*

If ICD-10-PCS is applicable, use the following Procedure Codes and Descriptions –

ICD-10-PCS Code	***Description***
30230AZ	*Transfusion of Embryonic Stem Cells into Peripheral Vein, Open Approach*
30230G0	*Transfusion of Autologous Bone Marrow into Peripheral Vein, Open Approach*
30230Y0	*Transfusion of Autologous Hematopoietic Stem Cells into Peripheral Vein, Open Approach*
30233G0	*Transfusion of Autologous Bone Marrow into Peripheral Vein, Percutaneous Approach*
30233Y0	*Transfusion of Autologous Hematopoietic Stem Cells into Peripheral Vein, Percutaneous Approach*
30240G0	*Transfusion of Autologous Bone Marrow into Central Vein, Open Approach*
30240Y0	*Transfusion of Autologous Bone Marrow into Central Vein, Open Approach*
30243G0	*Transfusion of Autologous Bone Marrow into Central Vein, Percutaneous Approach*
30243Y0	*Transfusion of Autologous Hematopoietic Stem Cells into Central Vein, Percutaneous Approach*
30250G0	*Transfusion of Autologous Bone Marrow into Peripheral Artery, Open Approach*
30250Y0	*Transfusion of Autologous Hematopoietic Stem Cells into Peripheral Artery, Open Approach*
30253G0	*Transfusion of Autologous Bone Marrow into Peripheral Artery, Percutaneous Approach*
30253Y0	*Transfusion of Autologous Hematopoietic Stem Cells into Peripheral Artery, Percutaneous Approach*
30260G0	*Transfusion of Autologous Bone Marrow into Central Artery, Open Approach*

ICD-10-PCS Code	*Description*
30260Y0	*Transfusion of Autologous Hematopoietic Stem Cells into Central Artery, Open Approach*
30263G0	*Transfusion of Autologous Bone Marrow into Central Artery, Percutaneous Approach*
30263Y0	*Transfusion of Autologous Hematopoietic Stem Cells into Central Artery, Percutaneous Approach*

B. - Covered Conditions

1. - Effective for services performed on or after April 28, 1989:

*For a*cute leukemia in remission *for* patients who have a high probability of relapse and who have no human leucocyte antigens (HLA)-matched, *the following diagnosis codes are reported:*

If ICD-9-CM is applicable, use the following Diagnosis Codes and Descriptions

Diagnosis Code	*Description*
204.01	*Lymphoid leukemia, acute, in remission*
205.01	*Myeloid leukemia, acute, in remission*
206.01	*Monocytic leukemia, acute, in remission*
207.01	*Acute erythremia and erythroleukemia, in remission*
208.01	*Leukemia of unspecified cell type, acute, in remission*

If ICD-10-CM is applicable, use the following Diagnosis Codes and Descriptions -

Diagnosis Code	*Description*
C91.01	*Acute lymphoblastic leukemia, in remission*
C92.01	*Acute myeloblastic leukemia, in remission*
C92.41	*Acute promyelocytic leukemia, in remission*
C92.51	*Acute myelomonocytic leukemia, in remission*
C92.61	*Acute myeloid leukemia with 11q23-abnormality in remission*
C92.A1	*Acute myeloid leukemia with multilineage dysplasia, in remission*
C93.01	*Acute monoblastic/monocytic leukemia, in remission*
C94.01	*Acute erythroid leukemia, in remission*
C94.21	*Acute megakaryoblastic leukemia, in remission*
C94.41	*Acute parmyelosis with myelofibrosis, in remission*
C95.01	*Acute leukemia of unspecified cell type, in remission*

*For r*esistant non-Hodgkin's lymphomas or those presenting with poor prognostic features following an initial response *the following diagnosis codes are reported:*

If ICD-9-CM is applicable, use the following code ranges:

200.00 - 200.08,
200.10 - 00.18,
200.20 - 200.28,
200.80 - 200.88,
202.00 - 202.08,
202.80 - 202.88, and
202.90 - 202.98.

If ICD-10-CM is applicable use the following code ranges:

C82.00 - C85.29,
C85.80 - C86.6,
C96.4, and
C96.Z - C96.9.

*For r*ecurrent or refractory neuroblastoma (see ICD-9-CM Neoplasm by site, malignant *for the appropriate diagnosis code)*

If ICD-10-CM is applicable the following ranges are reported:
C00 - C96, and
D00 - D09 Resistant non-Hodgkin's lymphomas

*For a*dvanced Hodgkin's disease patients who have failed conventional therapy and have no HLA-matched donor *the following diagnosis codes are reported:*

If ICD-9-CM is applicable, *201.00-201.98.*

If ICD-10-CM is applicable, *C81.00 – C81.99.*

2. - Effective for services performed on or after October 1, 2000:

Durie-Salmon Stage II or III that fit the following requirement are covered: Newly diagnosed or responsive multiple myeloma (*if ICD-9-CM is applicable, diagnosis* codes 203.00 and 238.6*, and, if ICD-10-CM is applicable, diagnosis codes C90.00 and D47.Z9*). This includes those patients with previously untreated disease, those with at least a partial response to prior chemotherapy (defined as a 50% decrease either in measurable paraprotein [serum and/or urine] or in bone marrow infiltration, sustained for at least 1 month), and those in responsive relapse, and adequate cardiac, renal, pulmonary, and hepatic function.

3. - Effective for Services On or After March 15, 2005

Effective for services performed on or after March 15, 2005, when recognized clinical risk factors are employed to select patients for transplantation, high-dose melphalan (HDM), together with AuSCT, in treating Medicare beneficiaries of any age group with primary amyloid light-chain (AL) amyloidosis who meet the following criteria:

- Amyloid deposition in 2 or fewer organs ; and,
- Cardiac left ventricular ejection fraction (EF) of 45% or greater.

C. - Noncovered Conditions

Insufficient data exist to establish definite conclusions regarding the efficacy of autologous stem cell transplantation for the following conditions:

- Acute leukemia not in remission*:*
    - *If ICD-9-CM is applicable, diagnosis* codes 204.00, 205.00, 206.00, 207.00 and 208.00 *are noncovered*;
    - *If ICD-10-CM is applicable, diagnosis codes C91.00, C92.00, C92.40, C92.50, C92.60, C92.A0, C93.00, C94.00, and C95.00 are noncovered.*
- Chronic granulocytic leukemia*:*
    - *If ICD-9-CM is applicable, diagnosis* codes 205.10 and 205.11;
    - *If ICD-10-CM is applicable, diagnosis codes C92.10 and C92.11.*
- Solid tumors (other than neuroblastoma):
    - *If ICD-9-CM is applicable, diagnosis* codes 140.0-199.1;
    - *If ICD-10-CM is applicable, diagnosis codes C00.0 - C80.2 and D00.0 - D09.9.*
- Multiple myeloma (ICD-9-CM code*s* 203.00 and 238.6), through September 30, 2000.
- Tandem transplantation (multiple rounds of autologous stem cell transplantation) for patients with multiple myeloma
    - *If ICD-9-CM is applicable, diagnosis* code*s* 203.00 and 238.6 *and,*
    - *If ICD-10-CM is applicable, diagnosis codes C90.00 and D47.Z9*)
- Non-primary (AL) amyloidosis,
    - *If ICD-9-CM is applicable, diagnosis* code 277.3. Effective October 1, 2000; *ICD-9-CM code 277.3 was expanded to codes 277.30, 277.31, and 277.39 effective October 1, 2006.*
    - *If ICD-10-CM is applicable, diagnosis codes are E85.0 – E85.9.* or
- Primary (AL) amyloidosis
    - *If ICD-9-CM is applicable, diagnosis* code*s* 277.3*0, 277.31, and 277.39 and* for Medicare beneficiaries age 64 or older, effective October 1, 2000, through March 14, 2005.
    - *If ICD-10-CM is applicable, diagnosis codes are E85.0 - E85.9.*

NOTE: Coverage for conditions other than these specifically designated as covered or non-covered is left to the discretion *of the A/B MAC (A)*.

90.3.3 - Billing for Stem Cell Transplantation

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD -10, Implementation: ICD -10: Upon Implementation of ICD -10, ASC X12: September, 23 2014)

A.- Billing for Allogeneic Stem Cell Transplants

1.- Definition of Acquisition Charges for Allogeneic Stem Cell Transplants

Acquisition charges for allogeneic stem cell transplants include, but are not limited to, charges for the costs of the following services:

- National Marrow Donor Program fees, if applicable, for stem cells from an unrelated donor;
- Tissue typing of donor and recipient;
- Donor evaluation;
- Physician pre-admission/pre-procedure donor evaluation services;
- Costs associated with harvesting procedure (e.g., general routine and special care services, procedure/operating room and other ancillary services, apheresis services, etc.);
- Post-operative/post-procedure evaluation of donor; and
- Preparation and processing of stem cells.

Payment for these acquisition services is included in the MS-DRG payment for the allogeneic stem cell transplant when the transplant occurs in the inpatient setting, and in the OPPS APC payment for the allogeneic stem cell transplant when the transplant occurs in the outpatient setting. The Medicare contractor does not make separate payment for these acquisition services, because hospitals may bill and receive payment only for services provided to the Medicare beneficiary who is the recipient of the stem cell transplant and whose illness is being treated with the stem cell transplant. Unlike the acquisition costs of solid organs for transplant (e.g., hearts and kidneys), which are paid on a reasonable cost basis, acquisition costs for allogeneic stem cells are included in prospective payment.

Acquisition charges for stem cell transplants apply only to allogeneic transplants, for which stem cells are obtained from a donor (other than the recipient himself or herself). Acquisition charges do not apply to autologous transplants (transplanted stem cells are obtained from the recipient himself or herself), because autologous transplants involve services provided to the beneficiary only (and not to a donor), for which the hospital may bill and receive payment (see Pub. 100-04, chapter 4, §231.10 and paragraph B of this section for information regarding billing for autologous stem cell transplants).

2.- Billing for Acquisition Services

The hospital bills and shows acquisition charges for allogeneic stem cell transplants based on the status of the patient (i.e., inpatient or outpatient) when the transplant is furnished. See Pub. 100-04, chapter 4, §231.11 for instructions regarding billing for acquisition services for allogeneic stem cell transplants that are performed in the outpatient setting.

When the allogeneic stem cell transplant occurs in the inpatient setting, the hospital identifies stem cell acquisition charges for allogeneic bone marrow/stem cell transplants separately by using revenue code 0819 (Other Organ Acquisition). Revenue code 0819 charges should include all services required to acquire stem cells from a donor, as defined above.

On the recipient’s transplant bill, the hospital reports the acquisition charges, cost report days, and utilization days for the donor’s hospital stay (if applicable) and/or charges for other encounters in which the stem cells were obtained from the donor. The donor is covered for medically necessary inpatient hospital days of care or outpatient care provided in connection with the allogeneic stem cell transplant under Part A. Expenses incurred for complications are paid only if they are directly and immediately attributable to the stem cell donation procedure. The hospital reports the acquisition charges on the billing form for the recipient, as described in the first paragraph of this section. It does not charge the donor's days of care against the recipient's utilization record. For cost reporting purposes, it includes the covered donor days and charges as Medicare days and charges.

The transplant hospital keeps an itemized statement that identifies the services furnished, the charges, the person receiving the service (donor/recipient), and whether this is a potential transplant donor or recipient. These charges will be reflected in the transplant hospital's stem cell/bone marrow acquisition cost center. For allogeneic stem cell acquisition services in cases that do not result in transplant, due to death of the intended recipient or other causes, hospitals include the costs associated with the acquisition services on the Medicare cost report.

The hospital shows charges for the transplant itself in revenue center code 0362 or another appropriate cost center. Selection of the cost center is up to the hospital.

B.- Billing for Autologous Stem Cell Transplants

The hospital bills and shows all charges for autologous stem cell harvesting, processing, and transplant procedures based on the status of the patient (i.e., inpatient or outpatient) when the services are furnished. It shows charges for the actual transplant, in revenue center code 0362 or another appropriate cost center. *ICD-9-CM or ICD-10-PCS codes are used to identify inpatient procedures.*

The CPT codes describing autologous stem cell harvesting procedures may be billed and are separately payable under the OPPS when provided in the hospital outpatient setting of care. Autologous harvesting procedures are distinct from the acquisition services described in Pub. 100-04, chapter 4, §231.11 and section A. above for allogeneic stem cell transplants, which include services provided when stem cells are obtained from a donor and not from the patient undergoing the stem cell transplant. The CPT codes describing autologous stem cell processing procedures also may be billed and are separately payable under the OPPS when provided to hospital outpatients.

Payment for autologous stem cell harvesting procedures performed in the hospital inpatient setting of care, with transplant also occurring in the inpatient setting of care, is included in the MS-DRG payment for the autologous stem cell transplant.

90.4.2 - Billing for Liver Transplant and Acquisition Services

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD -10, Implementation: ICD -10: Upon Implementation of ICD -10, ASC X12: September, 23 2014)

The inpatient claim 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 by revenue code 081X. 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 the liver transplant prospective payment. 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 081X 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

*T*he MCE contains a limited coverage edit for *liver transplant* procedure*s* using ICD-9-CM code 50.59 *if ICD-9 is applicable, and, if ICD-10 is applicable, using ICD-10-PCS codes 0FY00Z0, 0FY00Z1, and 0FY00Z2*.

Where *a liver transplant* procedure code 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 noncovered conditions are included in the covered diagnostic codes. (The diagnostic codes are broader than the covered conditions. 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.

90.5 - Pancreas Transplants with Kidney Transplants

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD -10, Implementation: ICD -10: Upon Implementation of ICD -10, ASC X12: September, 23 2014)

A. - Background

Effective July 1, 1999, Medicare covered pancreas transplantation when performed simultaneously with or following a kidney transplant *if ICD-9 is applicable, I*CD-9-CM procedure code 55.69. *If ICD-10 is applicable, the following ICD-10-PCS codes will be used:*

0TY00Z0,
0TY00Z1,
0TY00Z2,
0TY10Z0.

0TY10Z1, and
0TY10Z2.

Pancreas transplantation is performed to induce an insulin independent, euglycemic state in diabetic patients. The procedure is generally limited to those patients with severe secondary complications of diabetes including kidney failure. However, pancreas transplantation is sometimes performed on patients with labile diabetes and hypoglycemic unawareness.

Medicare has had a policy of not covering pancreas transplantation. The Office of Health Technology Assessment performed an assessment on pancreas-kidney transplantation in 1994. They found reasonable graft survival outcomes for patients receiving either simultaneous pancreas-kidney (SPK) transplantation or pancreas after kidney (PAK) transplantation. For a list of facilities approved to perform SPK or PAK, refer to the following Web site: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/downloads/ApprovedTransplantPrograms.pdf

B. - Billing for Pancreas Transplants

There are no special provisions related to managed care participants. Managed care plans are required to provide all Medicare covered services. Medicare does not restrict which hospitals or physicians may perform pancreas transplantation.

The transplant procedure and revenue code 0360 for the operating room are paid under these codes. Procedures must be reported using the current ICD procedure codes for pancreas and kidney transplants. Providers must place at least one of the following transplant procedure codes on the claim:

If ICD-9 Is Applicable

52.80 Transplant of pancreas
52.82 Homotransplant of pancreas

The Medicare Code Editor (MCE) has been updated to include 52.80 and 52.82 as limited coverage procedures. The contractor must determine if the facility is approved for the transplant and certified for either pediatric or adult transplants dependent upon the age of the patient.

Effective October 1, 2000, ICD-9-CM code 52.83 was moved in the MCE to non-covered. The contractor must override any deny edit on claims that came in with 52.82 prior to October 1, 2000 and adjust, as 52.82 is the correct code.

If the discharge date is July 1, 1999, or later: the contractor processes the bill through Grouper and Pricer.

If ICD-10 is applicable, the following procedure codes (ICD-10-PCS) are:

- *0FYG0Z0 Transplantation of Pancreas, Allogeneic, Open Approach*
- *0FYG0Z1 Transplantation of Pancreas, Syngeneic, Open Approach*

Pancreas transplantation is reasonable and necessary for the following diagnosis codes. However, since this is not an all-inclusive list, the contractor is permitted to determine if any additional diagnosis codes will be covered for this procedure.

If ICD-9-CM is applicable,* Diabetes Diagnosis Codes *and Descriptions

ICD-9-CM Code	***Description***

ICD-9-CM Code	*Description*
250.00	Diabetes mellitus without mention of complication, type II (non-insulin dependent) (NIDDM) (adult onset) or unspecified type, not stated as uncontrolled.
250.01	Diabetes mellitus without mention of complication, type I (insulin dependent) (IDDM) (juvenile), not stated as uncontrolled.
250.02	Diabetes mellitus without mention of complication, type II (non-insulin dependent) (NIDDM) (adult onset) or unspecified type, uncontrolled.
250.03	Diabetes mellitus without mention of complication, type I (insulin dependent) (IDDM) (juvenile), uncontrolled.
250.1X	Diabetes with ketoacidosis
250.2X	Diabetes with hyperosmolarity
250.3X	Diabetes with coma
250.4X	Diabetes with renal manifestations
250.5X	Diabetes with ophthalmic manifestations
250.6X	Diabetes with neurological manifestations
250.7X	Diabetes with peripheral circulatory disorders
250.8X	Diabetes with other specified manifestations
250.9X	Diabetes with unspecified complication

NOTE: X=0-3

If ICD-10-CM is applicable, the diagnosis codes are: *E10.10 - E10.9*

Hypertensive Renal Diagnosis Codes *and Descriptions if ICD-9-CM is applicable* :

ICD-9-CM Code	*Description*
403.01	Malignant hypertensive renal disease, with renal failure
403.11	Benign hypertensive renal disease, with renal failure
403.91	Unspecified hypertensive renal disease, with renal failure
404.02	Malignant hypertensive heart and renal disease, with renal failure
404.03	Malignant hypertensive heart and renal disease, with congestive heart failure or renal failure
404.12	Benign hypertensive heart and renal disease, with renal failure
404.13	Benign hypertensive heart and renal disease, with congestive heart failure or renal failure
404.92	Unspecified hypertensive heart and renal disease, with renal failure
404.93	Unspecified hypertensive heart and renal disease, with congestive heart failure or renal failure
585.1 - 585.6, 585.9	Chronic Renal Failure Code

If ICD-10-CM is applicable, diagnosis codes and descriptions are:

ICD-10-CM code	***Description***
I12.0	*Hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease*
I13.11	*Hypertensive heart and chronic kidney disease without heart failure, with stage 5 chronic kidney disease, or end stage renal disease*
I13.2	*Hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end stage renal disease*
N18.1	*Chronic kidney disease, stage 1*
N18.2	*Chronic kidney disease, stage 2 (mild)*
N18.3	*Chronic kidney disease, stage 3 (moderate)*
N18.4	*Chronic kidney disease, stage 4 (severe)*
N18.5	*Chronic kidney disease, stage 5*
N18.6	*End stage renal disease*
N18.9	*Chronic kidney disease, unspecified*

NOTE: If a patient had a kidney transplant that was successful, the patient no longer has chronic kidney failure, therefore it would be inappropriate for the provider to bill *ICD-9-CM codes* 585.1 - 585.6, 585.9 *or, if ICD-10-CM is applicable, the diagnosis codes N18.1 - N18.9* on such a patient. In these cases one of the following codes should be present on the claim or in the beneficiary's history.

The provider uses the following *ICD-9-CM status* codes only when a kidney transplant was performed before the pancreas transplant *and ICD-9 is applicable*:

ICD-9-CM code	***Description***
V42.0	Organ or tissue replaced by transplant kidney
V43.89	Organ tissue replaced by other means, kidney or pancreas

If ICD-10-CM is applicable, the following ICD-10-CM status codes will be used:

ICD-10-CM code	***Description***
Z48.22	*Encounter for aftercare following kidney transplant*
Z94.0	*Kidney transplant status*

NOTE: If a kidney and pancreas transplants are performed simultaneously, the claim should contain a diabetes diagnosis code and a renal failure code or one of the hypertensive renal failure diagnosis codes. The claim should also contain two transplant procedure codes. If the claim is for a pancreas transplant only, the claim should contain a diabetes diagnosis code and a *status* code to indicate a previous kidney transplant. If the *status* code is not on the claim for the pancreas transplant, the contractor will search the beneficiary's claim history for a *status* code *indicating a prior kidney transplant*.

C. - Drugs

If the pancreas transplant occurs after the kidney transplant, immunosuppressive therapy will begin with the date of discharge from the inpatient stay for the pancreas transplant.

D. - Charges for Pancreas Acquisition Services

A separate organ acquisition cost center has been established for pancreas transplantation. The Medicare cost report will include a separate line to account for pancreas transplantation costs. The 42 CFR 412.2(e)(4) was changed to include pancreas in the list of organ acquisition costs that are paid on a reasonable cost basis.

Acquisition costs for pancreas transplantation as well as kidney transplants will occur in Revenue Center 081X. The contractor overrides any claims that suspend due to repetition of revenue code 081X on the same claim if the patient had a simultaneous kidney/pancreas transplant. It pays for acquisition costs for both kidney and pancreas organs if transplants are performed simultaneously. It will not pay for more than two organ acquisitions on the same claim. In addition, the contractor remove acquisition charges prior to sending the claims to Pricer so such charges are not included in the outlier calculation.

E. - Medicare Summary Notices (MSN) and Remittance Advice Messages

If the provider submits a claim for simultaneous pancreas kidney transplantation or pancreas transplantation following a kidney transplant, and omits one of the appropriate diagnosis/procedure codes, the contractor rejects the claim, using the following MSN:

- MSN 16.32, "Medicare does not pay separately for this service."
- Use the following Remittance Advice Message:
- Claim adjustment reason code B15, *This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated*. ***Note:*** *Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.*

If a claim is denied because no evidence of a prior kidney transplant is presented, use the following MSN message:

- MSN 15.4, "The information provided does not support the need for this service or item."

The contractor uses the following Remittance Advice Message:

Claim adjustment reason code 50, *These are non-covered services because this is not deemed a 'medical necessity' by the payer.* ***Note:*** *Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.*

To further clarify the situation, the contractor should also use claim level remark code MA 126, "Pancreas transplant not covered unless kidney transplant performed."

90.5.1 – Pancreas Transplants Alone (PA)

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD -10, Implementation: ICD -10: Upon Implementation of ICD -10, ASC X12: September, 23 2014)

A. - General

Pancreas transplantation is performed to induce an insulin-independent, euglycemic state in diabetic patients. The procedure is generally limited to those patients with severe secondary complications of diabetes, including kidney failure. However, pancreas transplantation is sometimes performed on patients

with labile diabetes and hypoglycemic unawareness. Medicare has had a long-standing policy of not covering pancreas transplantation, as the safety and effectiveness of the procedure had not been demonstrated. The Office of Health Technology Assessment performed an assessment of pancreas-kidney transplantation in 1994. It found reasonable graft survival outcomes for patients receiving either simultaneous pancreas-kidney transplantation or pancreas-after-kidney transplantation.

B. - Nationally Covered Indications

CMS determines that whole organ pancreas transplantation will be nationally covered by Medicare when performed simultaneous with or after a kidney transplant. If the pancreas transplant occurs after the kidney transplant, immunosuppressive therapy will begin with the date of discharge from the inpatient stay for the pancreas transplant.

C. - Billing and Claims Processing

Contractors shall pay for Pancreas Transplantation Alone (PA) effective for services on or after April 26, 2006 when performed in those facilities that are Medicare-approved for kidney transplantation. Approved facilities are located at the following address: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/downloads/ApprovedTransplantPrograms.pdf

Contractors who receive claims for PA services that were performed in an unapproved facility, should reject such claims. Contractors should use the following messages upon the reject or denial:

- Medicare Summary Notice MSN Message - MSN code 16.2 (This service cannot be paid when provided in this location/facility)

- Remittance Advice Message - Claim Adjustment Reason Code 58. *Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.* ***Note:*** *Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.*

Payment will be made for a PA service performed in an approved facility, and which meets the coverage guidelines mentioned above for beneficiaries with type I diabetes.

All-Inclusive List of Covered Diagnosis Codes for PA *if ICD-9-CM is applicable*

(**NOTE: "**X" = 1 and 3 only)

ICD-9-CM code	***Description***
250.0X	Diabetes mellitus without mention of complication, type I (insulin dependent) (IDDM) (juvenile), not stated as uncontrolled.
250.1X	Diabetes with ketoacidosis
250.2X	Diabetes with hyperosmolarity
250.3X	Diabetes with coma
250.4X	Diabetes with renal manifestations
250.5X	Diabetes with ophthalmic manifestations
250.6X	Diabetes with neurological manifestations
250.7X	Diabetes with peripheral circulatory disorders
250.8X	Diabetes with other specified manifestations
250.9X	Diabetes with unspecified complication

If ICD-10-CM is applicable, , the provider uses the following range of ICD-10-CM codes:

E10.10 – E10.9.

Procedure Codes

If ICD-9 CM is applicable

52.80 - Transplant of pancreas
52.82 - Homotransplant of pancreas

If ICD-10 is applicable, the provider uses the following ICD-10-PCS codes:

0FYG0Z0 Transplantation of Pancreas, Allogeneic, Open Approach
0FYG0Z1 Transplantation of Pancreas, Syngeneic, Open Approach

Contractors who receive claims for PA that are not billed using the covered diagnosis/procedure codes listed above shall reject such claims. The MCE edits to ensure that the transplant is covered based on the diagnosis. The MCE also considers *ICD-9-CM codes* 52.80 and 52.82 *and ICD-10-PCS codes 0FYG0Z0 and 0FYG0Z1* as limited coverage dependent upon whether the facility is approved to perform the transplant and is certified for the age of the patient.

Contractors should use the following messages upon the reject or denial:

Medicare Summary Notice MSN Message - MSN code 15.4 The information provided does not support the need for this service or item

Remittance Advice Message - Claim Adjustment Reason Code 50 *These are non-covered services because this is not deemed a 'medical necessity' by the payer.* ***Note:*** *Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.*

Contractors shall hold the provider liable for denied\rejected claims unless the hospital issues a Hospital Issued Notice of Non-coverage (HINN) or a physician issues an Advanced Beneficiary Notice (ABN) for Part-B for physician services.

D. - Charges for Pancreas Alone Acquisition Services

A separate organ acquisition cost center has been established for pancreas transplantation. The Medicare cost report will include a separate line to account for pancreas transplantation costs. The 42 CFR 412.2(e)(4) was changed to include PA in the list of organ acquisition costs that are paid on a reasonable cost basis.

Acquisition costs for PA transplantation are billed in Revenue Code 081X. The contractor removes acquisition charges prior to sending the claims to Pricer so such charges are not included in the outlier calculation.

90.6 - Intestinal and Multi-Visceral Transplants

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD -10, Implementation: ICD -10: Upon Implementation of ICD -10, ASC X12: September, 23 2014)

A. - Background

Effective for services on or after April 1, 2001, Medicare covers intestinal and multi-visceral transplantation for the purpose of restoring intestinal function in patients with irreversible intestinal failure. Intestinal failure is defined as the loss of absorptive capacity of the small bowel secondary to severe primary gastrointestinal disease or surgically induced short bowel syndrome. Intestinal failure prevents oral nutrition and may be associated with both mortality and profound morbidity. Multi-Visceral transplantation includes organs in the digestive system (stomach, duodenum, liver, and intestine). See §260.5 of the National Coverage Determinations Manual for further information.

B. - Approved Transplant Facilities

Medicare will cover intestinal transplantation if performed in an approved facility. The approved facilities are located at: *https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/downloads/ApprovedTransplantPrograms.pdf*

C. - Billing

If ICD-9-CM is applicable, ICD-9-CM procedure code 46.97 is effective for discharges on or after April 1, 2001. *If ICD-10 is applicable, the ICD-10-PCS procedure codes are 0DY80Z0, 0DY80Z1, 0DY80Z2, 0DYE0Z0, 0DYE0Z1, and 0DYE0Z2.* The Medicare Code Editor (MCE) lists *these codes* as limited coverage procedure*s*. The contractor shall override the MCE when this procedure code is listed and the coverage criteria are met in an approved transplant facility, and also determine if the facility is certified for adults and/or pediatric transplants dependent upon the patient's age.

For *these procedures* where the provider is approved as transplant facility and certified for the adult and/or pediatric population, and the service is performed on or after the transplant approval date, the contractor must suspend the claim for clerical review of the operative report to determine whether the beneficiary has at least one of the covered conditions listed when the diagnosis code is for a covered condition.

This review is not part of the contractor's medical review workload. Instead, the contractor should complete this review as part of its claims processing workload.

*If ICD-9-CM is applicable, c*harges for ICD-9-CM procedure code 46.97*, and, if ICD-10 is applicable, the ICD-10-PCS procedure codes 0DY80Z0, 0DY80Z1, 0DY80Z2, 0DYE0Z0, 0DYE0Z1, or 0DYE0Z2* should be billed under revenue code 0360, Operating Room Services.

For discharge dates on or after October 1, 2001, acquisition charges are billed under revenue code 081X, Organ Acquisition. For discharge dates between April 1, 2001, and September 30, 2001, hospitals were to report the acquisition charges on the claim, but there was no interim pass-through payment made for these costs.

Bill the procedure used to obtain the donor's organ on the same claim, using appropriate ICD procedure codes.

The 11X bill type should be used when billing for intestinal transplants.

Immunosuppressive therapy for intestinal transplantation is covered and should be billed consistent with other organ transplants under the current rules.

*If ICD-9-CM is applicable, t*here is no specific ICD-9-CM diagnosis code for intestinal failure. Diagnosis codes exist to capture the causes of intestinal failure. Some examples of intestinal failure include but are not limited to *the following conditions and their associated ICD-9-CM codes*:

- Volvulus 560.2,
- Volvulus gastroschisis 756.79, other [congenital] anomalies of abdominal wall,

- Volvulus gastroschisis 569.89, other specified disorders of intestine,
- Necrotizing enterocolitis 777.5, necrotizing enterocolitis in fetus or newborn,
- Necrotizing enterocolitis 014.8, other tuberculosis of intestines, peritoneum, and mesenteric,
- Necrotizing enterocolitis and splanchnic vascular thrombosis 557.0, acute vascular insufficiency of intestine,
- Inflammatory bowel disease 569.9, unspecified disorder of intestine,
- Radiation enteritis 777.5, necrotizing enterocolitis in fetus or newborn, and
- Radiation enteritis 558.1.

If ICD-10-CM is applicable, some diagnosis codes that may be used for intestinal failure are:

- *Volvulus K56.2,*
- *Enteroptosis K63.4,*
- *Other specified diseases of intestine K63.89,*
- *Other specified diseases of the digestive system K92.89,*
- *Postsurgical malabsorption, not elsewhere classified K91.2,*
- *Other congenital malformations of abdominal wall Q79.59,*
- *Necrotizing enterocolitis in newborn, unspecified P77.9,*
- *Stage 1 necrotizing enterocolitis in newborn P77.1,*
- *Stage 2 necrotizing enterocolitis in newborn P77.2, and*
- *Stage 3 necrotizing enterocolitis in newborn P77.3.*

D. - Acquisition Costs

A separate organ acquisition cost center was established for acquisition costs incurred on or after October 1, 2001. Therefore, acquisition charges billed on revenue code 081x are removed from the claim's total covered charges so as to not be included in the IPPS outlier calculation. The Medicare Cost Report will include a separate line to account for these transplantation costs.

For intestinal and multi-visceral transplants performed between April 1, 2001, and October 1, 2001, the DRG payment was payment in full for all hospital services related to this procedure.

E. - Medicare Summary Notices (MSN), Remittance Advice Messages, and Notice of Utilization Notices (NOU)

If an intestinal transplant is billed by an unapproved facility after April 1, 2001, the contractor shall deny the claim and use MSN message 21.6, "This item or service is not covered when performed, referred, or ordered by this provider;" 21.18, "This item or service is not covered when performed or ordered by this provider;" or, 16.2, "This service cannot be paid when provided in this location/facility;" and Remittance Advice

Message, Claim Adjustment Reason Code 52, "The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed."

100.1 - Billing for Abortion Services

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD -10, Implementation: ICD -10: Upon Implementation of ICD -10, ASC X12: September, 23 2014)

Effective October 1, 1998**,** abortions are not covered under the Medicare program except for instances where the pregnancy is a result of an act of rape or incest; or the woman suffers from a physical disorder, physical injury, or physical illness, including a life endangering physical condition caused by the pregnancy itself that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

A. - "G" Modifier

The "G7" modifier is defined as "the pregnancy resulted from rape or incest, or pregnancy certified by physician as life threatening."

Beginning July 1, 1999, providers should bill for abortion services using the new Modifier G7. This modifier can be used on claims with dates of services October 1, 1998, and after. CWF will be able to recognize the modifier beginning July 1, 1999.

B. - ***A/B MAC (A)*** **Billing Instructions**

1. **Hospital Inpatient Billing**

Hospitals use bill type 11X. Medicare will pay only when *one of the following* condition codes *is reported*:

Condition Code	***Description***
AA	Abortion Performed due to Rape
AB	Abortion Performed due to Incest
AD	Abortion Performed due to life endangering physical condition

With *one of the following:*

If ICD-9-CM Is Applicable:

- an appropriate ICD principal diagnosis code that will group to DRG 770 (Abortion W D&C, Aspiration Curettage Or Hysterotomy) or
- an appropriate ICD principal diagnosis code and one of the following ICD-9-CM operating room procedure that will group to DRG 779 (Abortion W/O D&C):69.01, 69.02, 69.51, 74.91.

If ICD-10-CM is applicable, one of the following ICD-10-PCS codes are used:

ICD-10-PCS code	***Description***
10A07ZZ	*Abortion of Products of Conception, Via Natural or Artificial Opening*
10A08ZZ	*Abortion of Products of Conception, Via Natural or Artificial Opening Endoscopic*
10D17ZZ	*Extraction of Products of Conception, Retained, Via Natural or Artificial Opening*

ICD-10-PCS code	*Description*
10D18ZZ	*Extraction of Products of Conception, Retained, Via Natural or Artificial Opening Endoscopic*
10A07ZZ	*Abortion of Products of Conception, Via Natural or Artificial Opening*
10A08ZZ	*Abortion of Products of Conception, Via Natural or Artificial Opening Endoscopic*
10A00ZZ	*Abortion of Products of Conception, Open Approach*
10A03ZZ	*Abortion of Products of Conception, Percutaneous Approach*
10A04ZZ	*Abortion of Products of Conception, Percutaneous Endoscopic Approach*

Providers must use ICD-9-CM codes 69.01 and 69.02 *if ICD-9-CM is applicable*, or, *if ICD-10-CM is applicable,* the related 1CD-10-*PCS* codes to describe exactly the procedure or service performed.

The *A/B MAC (A)* must manually review claims with the above ICD-9-CM/ICD-10-*PCS* procedure codes to verify that all of the above conditions are met.

2. **Outpatient Billing**

Hospitals will use bill type 13X and 85X. Medicare will pay only if one of the following CPT codes is used with the "G7" modifier.

59840	59851	59856
59841	59852	59857
59850	59855	59866

C. - Common Working File (CWF) Edits

For hospital outpatient claims, CWF will bypass its edits for a managed care beneficiary who is having an abortion outside their plan and the claim is submitted with the "G7" modifier and one of the above CPT codes.

For hospital inpatient claims, CWF will bypass its edits for a managed care beneficiary who is having an abortion outside their plan and the claim is submitted with one of the above *inpatient* procedure codes.

D. - Medicare Summary Notices (MSN)/Explanation of Your Medicare Benefits Remittance Advice Message

If a claim is submitted with one of the above CPT procedure codes but no "G7" modifier, the claim is denied. The *A/B MAC (A)* states on the MSN the following message:

> This service was denied because Medicare covers this service only under certain circumstances." (MSN Message 21.21).

For the remittance advice the *A/B MAC (A)* uses existing *ASC* X12-835 claim adjustment reason code B5, "Claim/service denied/reduced because coverage guidelines were not met or were exceeded."

100.7 – Lung Volume Reduction Surgery

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD -10, Implementation: ICD -10: Upon Implementation of ICD -10, ASC X12: September, 23 2014)

Lung Volume Reduction Surgery (LVRS) (also known as reduction pneumoplasty, lung shaving, or lung contouring) is an invasive surgical procedure to reduce the volume of a hyperinflated lung in order to allow the underlying compressed lung to expand, and thus, establish improved respiratory function.

Effective for discharges on or after January 1, 2004, Medicare will cover LVRS under certain conditions as described in §240 of Pub. 100-03, "National Coverage Determinations".

The Medicare Code Editor (MCE) creates a Limited Coverage edit for *ICD-9-CM* procedure code 32.22. This procedure code has limited coverage due to the stringent conditions that must be met by hospitals. Where this procedure code is identified by MCE, the *A/B MAC (A)* shall determine if coverage criteria is met and override the MCE if appropriate.

Effective with the implementation of ICD-10 there will not be an MCE edit for lung volume reduction surgery.

The LVRS can only be performed in the facilities listed on the following Web site: *http://www.cms.gov/Medicare/Medicare-General-Information/MedicareApprovedFacilitie/Lung-Volume-Reduction-Surgery-LVRS.html*

Medicare previously only covered LVRS as part of the National Emphysema Treatment Trial (NETT). The study was limited to 18 hospitals, and patients were randomized into two arms, either medical management and LVRS or medical management. The study was conducted by The National Heart, Lung, and Blood Institute of the National Institutes of Health and coordinated by Johns Hopkins University (JHU). Hospital claims for patients in the NETT were identified by the presence of Condition Code EY. The JHU instructed hospitals of the correct billing procedures for billing claims under the NETT.

110.9 - Nonemergency Part B Medical and Other Health Services

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD -10, Implementation: ICD -10: Upon Implementation of ICD -10, ASC X12: September, 23 2014)

A - Coverage

Nonemergency services to Medicare beneficiaries may be paid for if the coverage requirements for the services are met, and are not covered as Part A emergency inpatient services.

Program payment may be made for the following Part B medical and other health services furnished by a U.S. nonparticipating hospital on a nonemergency basis:

- Diagnostic x-ray tests, diagnostic laboratory tests and other diagnostic tests. (The hospital must meet the applicable conditions of participation for the services.)

- X-ray, radium, and radioactive isotope therapy, including materials and services of technicians. (The hospital must meet the applicable conditions of participation for these services.)

- Services of residents and interns, nurses, therapists, etc., which are directly related to the provision of x-ray or laboratory or other diagnostic tests, or the provisions of x-ray or radium therapy.

- Prosthetic devices (other than dental) which replace all or part of an internal body organ (including contiguous tissue) or replace all or part of the functions of a permanently inoperative or malfunctioning internal body organ, including replacement of such devices.

- Leg, arm, back, and neck braces, trusses and artificial legs, arms, and eyes, including replacement, if required, because of a change in the patient's physical condition.

B - Distinction Between Emergency and Nonemergency Medical and Other Health Services

Emergency coverage, particularly Part B emergency outpatient coverage, is broader than the nonemergency Part B Medical and Other Health Services coverage provisions. When the emergency requirements are met, program payment may be made to the hospital for the full range of outpatient hospital services. In addition to the nonemergency coverage list, emergency coverage includes hospital services (including drugs and biologicals - blood is a biological - which cannot be self-administered), "incident to physicians' services rendered to outpatients," and outpatient physical therapy and speech-language pathology. The latter two services are not covered under the nonemergency provisions. Payment for "incident to" services can be only under the emergency rather than the nonemergency provisions.

Whether Part B payment is made under the emergency or nonemergency provisions, it may be made for diagnostic laboratory tests furnished by an emergency hospital only if the hospital meets the conditions of participation relating to hospital laboratories. It may be made only for radiology services furnished by an emergency hospital if the hospital meets the conditions of participation relating to radiology departments. Part B payment may be made for diagnostic laboratory tests furnished by a nonparticipating hospital which is not an emergency hospital only if the hospital laboratory meets the conditions of coverage of independent laboratories and for radiology services furnished by it, only if it meets the conditions of participation relating to radiology departments.

C - Claims Processing

The hospital enters the annotation "nonemergency-hospital accepts assignment" in *the claim* Remarks *field*. If it is determined that some or all of the services are not covered under the nonemergency provisions, the claim is returned to it (if hospital-filed) or to the beneficiary (if patient-filed) to determine whether the services might be covered as emergency services.

110.11 - Elections to Bill for Services Rendered Nonparticipating Hospitals

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD -10, Implementation: ICD -10: Upon Implementation of ICD -10, ASC X12: September, 23 2014)

A. - Nonparticipating U.S. Hospitals

As a nonparticipating U.S. hospital meeting emergency requirements, the hospital has the option to bill the program during a calendar year by filing an election with its FI. If it files an election, it should submit claims for the following services furnished all Medicare beneficiaries throughout the year:

- Emergency inpatient services; and
- Emergency outpatient services.

In addition, the hospital may not bill any beneficiary beyond deductibles, coinsurance, and noncovered services in that calendar year. It must agree to refund any monies incorrectly collected. It may not file an election for the calendar year if it has already charged any beneficiary for covered services furnished in that year.

If the hospital does not file a billing election, the beneficiary can file a claim. The beneficiary may request information from the hospital or the *A/B MAC (A)* as appropriate.

During November of each year, the *A/B MAC (A)* will send the non-participating hospital a letter (see §120.3.1). Also, during November of each year, the *A/B MAC (A)* will send a letter to each domestic hospital, giving it an opportunity to elect to bill Medicare if it has not been doing so (§120.3.2).

If during the year the hospital requests to bill the program, its *A/B MAC (A)* will send the model letter in §120.3.3.

B. - Billing for Services Furnished Prior to Certification

The following rules apply if a bill is submitted for services rendered before and after a hospital's certification (participation) date:

- PPS hospitals are paid the DRG, if the date of discharge is after the certification date.
- Other hospitals are paid for services rendered after the certification date. However, the hospital must include services before certification date on its cost report.

It should annotate in the upper right hand corner of the claim "Emergency Conversion."

C. - Foreign Hospitals

Foreign hospitals may submit a statement to the appropriate *A/B MAC (A)* stating that they will bill for all claims. If they do not, the beneficiary may claim the payment. When the *A/B MAC (A)* is aware that a hospital is willing to bill the program for all covered services, it solicits the hospital's agreement to:

- Bill for all covered services for the calendar year (except for deductible and coinsurance amounts);
- Not bill the beneficiary for any amounts other than for deductible and coinsurance and charges for noncovered services; and
- Refund to the beneficiary any monies incorrectly collected.

A hospital may not file an election for a calendar year if it has charged any beneficiary for covered services during that year.

D. - Submitting Claims

The beneficiary or the hospital that has elected to bill the program may submit emergency claims for payment to the appropriate *A/B MAC (A)* for evaluation of accessibility or emergency factors.

The hospital completes the claim according to billing instructions in Chapter 25. It enters "hospital filed emergency admission" in *the* Remarks field. It sends the completed bill and the necessary emergency documentation (Form CMS-1771, Attending Physicians Statement and Documentation of Medicare Emergency) or medical records to substantiate the emergency to the appropriate FI.

NOTE: See §120.2, "Designated *Contractors*."

If the hospital submits a claim but has not filed an election to bill the program, it will be contacted to determine if it is qualified and wish to bill the program. If it declines, the claim will be denied. A claim will be solicited from the beneficiary.

If the hospital has filed a billing election and the beneficiary files a claim, the beneficiary's claim is denied and the hospital is contacted for the claim.

120 - Payment for Services Received in Nonparticipating Providers

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD -10, Implementation: ICD -10: Upon Implementation of ICD -10, ASC X12: September, 23 2014)

The *ASC X12 837 institutional claim format or the* Form CMS-1450 must be used.

A. - Hospital Filed Claims

1. - Inpatient Services

The payment rate for inpatient claims is the lower of: 90 percent of the hospital's average inpatient per diem cost for all patients, or 85 percent of its regular charge for the services rendered. Its average per diem cost is determined from the most recent calculation of the average per diem cost by a non-Governmental third-party payer.

The cost of the services is adjusted by any applicable deductible and coinsurance amounts for which the beneficiary is responsible.

Payment will be made to Federal hospitals that furnish emergency services, on an inpatient basis, to individuals entitled to hospital benefits. Payment will be based on the lower of the actual charges from the hospital or rates published for Federal hospitals in the "Federal Register" under **Office of Management and Budget - Cost of Hospital and Medical Care and Treatment Furnished by the United States; Certain Rates Regarding Recovery from Tortiously Liable Third Persons**.

Medicare will not pay Federal hospitals for emergency items or services furnished to veterans, retired military personnel or eligible dependents. However, Medicare can pay for the inpatient deductible charged by VA hospitals, or credit that amount to the Medicare Part A deductible, for emergency services furnished to veterans. If a Part A claim is denied, a denial notice will be forwarded to the beneficiary from the *A/B MAC (A)*. The beneficiary can use this notice to forward to their private insurer, if applicable.

The VA or DOD hospital must file a statement of election for each calendar year to receive direct payment from Medicare for all claims filed that year.

2. - Outpatient Services

The amount paid by Medicare for emergency outpatient claims is obtained as follows:

- Eighty-five percent of the total covered charges is the estimated cost figure. The applicable Part B deductible is subtracted. Coinsurance is subtracted from the remainder.

- Subtracting the deductible from 85 percent of the total covered charges and applying the 20 percent coinsurance rate to the remainder obtains the patient's coinsurance amount. The hospital will be paid cost (85 percent of covered charges) minus deductible and coinsurance.

3. - Part B Medical and Other Health Services

Part B medical and other health services, including hospital-based ambulance services whether hospital or beneficiary filed, may be covered and paid on a non-emergency basis. To calculate the amount paid by Medicare, the hospital subtracts the Part B deductible from the total covered charges and applies the 80 percent payment rate.

4. - Special Letters for Partially or Totally Denied (Hospital-Filed) Claims for Emergency Inpatient Services

The patient receives a notice from CMS covering the emergency payment of a partially denied claim. A denial letter and a Part B explanation of benefits is sent to the patient. The *A/B MAC (A)* includes its address on this letter.

B. - Beneficiary Filed Claim

1. - Emergency Inpatient Claims

The payment computation follows:

- Any noncovered accommodation charge is subtracted from the total accommodation charges. The amount of the inpatient deductible or coinsurance met on this bill is subtracted. Any remainder is multiplied by 60 percent.

- The total noncovered ancillary charge is subtracted from the total ancillary charge. Any inpatient deductible or coinsurance that remains is subtracted. The remainder is multiplied by 80 percent.

- The benefit amounts obtained are added.

2. - Emergency Outpatient Services

To calculate the amount paid by Medicare, the hospital must subtract any applicable Part B deductible from the total covered charges and apply the 80 percent payment rate.

3. - Part B Medical and Other Health Services

Part B medical and other health services furnished by nonparticipating hospitals, including hospital-based ambulance services, may be covered and paid on an non-emergency basis.

To calculate the amount paid by Medicare, the hospital must subtract any applicable Part B deductible from the total covered charges and apply an 80 percent payment rate.

4. - Special Letters for Patient-Filed Claims for Emergency Inpatient Services

For emergency admissions to nonparticipating hospitals where direct payment is made to the patient, the *A/B MAC (A)* sends the beneficiary one of the letters described below, as appropriate.

The letter explains the Part A payments made. Part B payments are made for ancillary services not covered by Part A and are also explained in a letter. This letter also explains the beneficiary's right of appeal.

The *A/B MAC (A)* retains a duplicate of all notices sent for documentation in any appeals process. It enters the date the notice is released on both copies of all notices.

Sample paragraphs:

- "Enclosed is a check for $_____, which is the amount Medicare can pay for inpatient hospital services you received from (date of admission) to (date of discharge) in (hospital)."

- "Medicare is able to pay 60 percent of the charges for your room and board plus 80 percent of the charges for all other covered services during the period (date emergency began) to (date payment ended)."

  "Medicare is able to pay 60 percent of the charges for your room and board, 80 percent of the charges for other separately identified charges, and 66 2/3 percent of the other charges which were not separately identified on the hospital bill."

- "Medicare does not pay (the first $ ____ of charges) (the first three pints of blood) ($ ____ a day after the 60th day) in a benefit period. (Select one or more, if applicable.)"

- "If lifetime reserve days are used, add $ ___ a day from _____ to _____."

- "If you believe your Medicare hospital insurance should have covered all or more of your expenses, you may get in touch with us at the address shown on this letter."

- "If you believe that the determination is not correct, you may request a reconsideration for hospital insurance (or a review for medical insurance). You may make the request by mail to the address shown on this letter. If you come in person, please bring this notice with you."

- "This check includes a medical insurance payment for 80 percent of the charges for certain nonroutine hospital services which you received from _____ through _____. These services are listed on the enclosed form."

- "If a hospital bill is not itemized, Medicare can pay 66 2/3 percent of the total covered charges. Payment is being made at this rate for charges from (date emergency began) to (date payment ended)."

- "We are enclosing a check for $ _____. This is your payment under Part B for 80 percent of the charges for the services which you received from (admission date) through (discharge date) while in (name of hospital). These services are listed on the enclosed form."

When payment cannot be made under hospital insurance, medical insurance covers some, but not all, of the hospital services. Room and board and certain other services are not covered by medical insurance.

140.1.3 - Verification Process Used To Determine If The Inpatient Rehabilitation Facility Met The Classification Criteria

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD -10, Implementation: ICD -10: Upon Implementation of ICD -10, ASC X12: September, 23 2014)

A. - Determination of the Compliance Review Time Period.

1. General Guideline To Determine The Compliance Review Period. In general, the RO and *A/B MAC (A)* will use data from the most recent, consecutive, and appropriate 12-month time period (as defined by CMS) that starts on or after July 1, 2004, to determine if a facility is in compliance with all of the criteria used to classify a facility as an IRF. The RO and *A/B MAC (A)* will notify the facility of the time period that will be used. The RO and *A/B MAC (A)* will begin reviewing data 4 months prior to the start of the facility's next cost reporting period.

The compliance review periods are determined based on the following:

1. Guidelines for Determining Compliance Review Periods For IRFs With Cost Reporting Periods That Start Between July 1, 2004 and October 31, 2004.

   Data prior to July 1, 2004 will not be used to determine an IRF's compliance with the requirements in §140.1.1B-D. Thus, for IRFs with cost reporting periods beginning on or after July 1, 2004 and before November 1, 2004, less than 12 months of data will be used in their first compliance review period after July 1, 2004. Refer to the first 5 rows of the Table of Compliance Review Periods (below) for an illustration of this.

2. Guidelines for Determining an IRF's Compliance Percentage When the Required Compliance Percentage Threshold Differs Across Two Cost Reporting Periods

   When a cost reporting period starts on or after July 1, 2005, but not later than June 30, 2006, and the compliance review period spans two cost reporting periods, the compliance percentage is calculated using either of the following two methods. The IRF must have a patient population in each of the two portions of time in order to use either of the two methods described below.

   (A) The IRF must meet the applicable compliance percentage threshold in each of the two portions of the compliance review period separately, as illustrated in the example below.

The following is an example of how this first method would be applied:

The compliance review period for an IRF that has a cost reporting period from July 1, 2005 through June 30, 2006 is March 1, 2005 to February 28, 2006.

The IRF must meet a compliance threshold of 50 percent for the cost reporting period of July 1, 2004 to June 30, 2005.

The IRF must meet a compliance threshold of 60 percent for the cost reporting period of July 1, 2005 to June 30, 2006.

In this example, the first portion of the compliance review period (from March 1, 2005 to June 30, 2005) is part of the IRF's cost reporting period that started on July 1, 2004 and ends on June 30, 2005. The second portion of the compliance review period (from July 1, 2005 to February 28, 2006) is part of the IRF's cost reporting period that starts on July 1, 2005 and ends on June 30, 2006.

Therefore,

For the portion of the compliance review period from March 1, 2005 to June 30, 2005, the compliance percentage threshold that the IRF must meet is 50 percent.

For the portion of the compliance review period from July 1, 2005 to February 28, 2006, the compliance percentage threshold that the IRF must meet is 60 percent.

If the IRF does not meet the compliance percentage threshold of 50 percent for the March 1, 2005 to June 30, 2005 portion of the compliance review time period, or the compliance percentage threshold of 60 percent for the July 1, 2005 to February 28, 2006 portion of the compliance review time period, it will be determined that the IRF failed to meet the compliance percentage threshold for the entire compliance review period consisting of March 1, 2005 to February 28, 2006.

(B) The *A/B MAC (A)* computes one weighted average compliance percentage for the entire 12-month compliance review period. The resulting weighted average compliance percentage will be used to determine if the facility met the compliance threshold requirements in §140.1.1B-D.

The following is an example of how this second method would be applied:

The compliance review period for an IRF that has a cost reporting period from August 1, 2005 to July 31, 2006 is April 1, 2005 to March 31, 2006. However, the compliance review period is divided into two portions: April 1, 2005 to July 31, 2005 and August 1, 2005 to March 31, 2006.

In the following hypothetical example, 45 percent of the cases met at least one of the medical conditions listed above in §140.1.1C from April 1, 2005 to July 31, 2005, and 80 percent of the cases met at least one of the medical conditions listed in §140.1.1C from August 1, 2005 to March 31, 2006. The weighted average compliance percentage from the two portions of time must be calculated as follows for compliance review periods beginning on or after January 1, 2013.

4/12 = 0.333 which is rounded to 0.33
8/12 = 0.666 which is rounded to 0.67

0.33 X 45% = 0.1485
0.67 X 80% = 0.5360

0.1485 + 0.5360 = 0.6845 which is rounded to 68%

Based on this result of 68 percent from the weighted average calculation, it will be determined that the IRF met the compliance percentage threshold for the compliance review period starting on April 1, 2005.

3. Guidelines for Determining an IRF's Compliance Percentage When the Required Compliance Percentage Threshold Is the Same for the Entire Compliance Review Period

To minimize the level of effort required by Medicare contractors and IRFs, contractors must review one continuous 12-month period if the compliance percentage threshold is the same throughout the entire compliance review period for all compliance review periods beginning on or after January 1, 2013.

4. Guidelines for Determining the Compliance Review Period of a Facility Classified as a New IRF. According to the regulations in §412.25(c), a new IRF can only begin being paid under the IRF PPS at the start of a cost reporting period. If the IRF begins treating patients prior to the start of a cost reporting period, it may receive payment under the IPPS until the start of the next cost reporting period, at which point it can begin receiving payment under the IRF PPS if it meets all of the applicable requirements in §412.25 and §412.29. A new IRF will have a compliance review period that starts immediately when its cost reporting period starts, and ends four months before the start of its next cost reporting period. For example, if a facility has a cost reporting period that starts on July 1, 2012 and is a new IRF, its compliance review period would start on July 1, 2012 and end on February 28, 2013. Thus, a facility classified as a new IRF will have an initial compliance review period that is 8 months in length, in order to allow the RO and *A/B MAC (A)* a 4-month time period to make and administer a compliance determination.

5. Guidelines for Determining an IRF's Compliance When the IRF Expands its Bed Capacity. Effective October 1, 2011, as long as an IRF meets all of the applicable requirements in §412.25(b) and 412.29(c)(2), it may add new beds one time, at any time, during a cost reporting period. The IRF must provide written certification that the inpatient population it intends to serve (including the patients served in the new beds) meets the requirements in §412.29(b). In addition, the new IRF beds will be included in the compliance review calculations under §412.29(b) from the time that they are added to the IRF.

6. Guidelines for Determining the Compliance Review Period of a Facility That Changes Its Cost Reporting Period. A facility that changes its cost reporting period will have a new compliance review period that is based on its new cost reporting period. For example, if an IRF changes the start of its cost reporting period from July 1, 2011 to October 1, 2011, then the start date of its compliance review period will also change from March 1, 2011 to June 1, 2011. Excessive changes to cost reporting periods are not permitted.

The table below entitled "Examples of Compliance Review Periods" provides examples of compliance review periods associated with various cost reporting periods.

Examples of Compliance Review Periods. For a facility that has been classified as an IRF, but is not a "new" IRF as defined below in §140.1.4, the following table provides examples of the compliance review periods associated with different cost reporting periods.

Examples of Compliance Review Periods

Start Date of the Cost Reporting Period for Which a Facility Will (or Will Not) be Classified (or Retain Classification) as an IRF	Compliance Review Period: (Admissions or Discharges During)	# of Months in Review Period	Compliance Percentage Threshold
07/01/2005	07/01/2004 - 02/28/2005	8	50%
08/01/2005	07/01/2004 - 03/31/2005	9	50%
09/01/2005	07/01/2004 - 04/30/2005	10	50%
10/01/2005	07/01/2004 - 05/31/2005	11	50%
11/01/2005	07/01/2004 - 06/30/2005	12	50%
07/01/2006	03/01/2005 - 02/28/2006	12	03/01/2005 to 06/30/2005: 50 % 07/01/2005 to 02/28/2006: 60 %
08/01/2006	04/01/2005- 03/31/2006	12	04/01/2005 to 07/31/2005: 50 % 08/01/2005 to 03/31/2006: 60 %
09/01/2006	05/01/2005- 04/30/2006	12	05/01/2005 to 08/31/2005: 50 % 09/01/2005 to 04/30/2006: 60 %
10/01/2006	06/01/2005- 05/31/2006	12	06/01/2005 to 09/30/2005: 50 % 10/01/2005 to 05/31/2006: 60 %
11/01/2006	07/01/2005- 06/30/2006	12	07/01/2005 to 10/31/2005: 50 % 11/01/2005 to 06/30/2006: 60 %
12/01/2006	08/01/2005- 07/31/2006	12	08/01/2005 to 11/30/2005: 50% 12/01/2005 to 07/31/2006: 60%

For cost reporting periods beginning on or after July 1, 2005, the compliance threshold that must be met is 60 percent. Thus, for all compliance review periods beginning on or after January 1, 2013 (except in the case of new IRFs, as described in section 140.3.4 above), the compliance review period will be one continuous 12-month time period beginning 4 months before the start of a cost reporting period and ending 4 months before the beginning of the next cost reporting period.

B. - Types of Data Used to Determine Compliance with the Classification Criteria

1. Starting on July 1, 2004, the *A/B MAC (A)* will use the verification procedures specified below in subsection C which is entitled "Verification of the Medical Condition Criterion Using the Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI) Data Records" or subsection D which is entitled "Verification of the Medical Condition Criterion Using the Inpatient Rehabilitation Facility's Total Inpatient Population" to verify that an IRF has complied with the requirements specified above in §140.1.1B-D.

2. The verification procedure specified below in subsection C (that is, verification using the IRF-PAI data) will only be used if the *A/B MAC (A)* has verified that the IRF's Medicare Part A fee-for-service inpatient population is at least 50 percent of the IRF's total inpatient population. Effective for compliance review periods beginning on or after October 1, 2009, *A/B MACs (A)* must include the IRF's Medicare Part C (Medicare Advantage) inpatient population, along with the IRF's Medicare Part A fee-for-service inpatient population, in determining whether at least 50 percent of the IRF's total inpatient population is made up of Medicare patients.

3. General Guideline Regarding Submission of a List of the Inpatients in Each IRF: In order to verify that an IRF's Medicare Part A fee-for-service and Medicare Part C (Medicare Advantage) inpatient populations (combined) reflect the IRF's total inpatient population, the *A/B MAC (A)* in writing will instruct the IRF to send the *A/B MAC (A)*, by a specific date, a list showing the hospital patient number of each inpatient IRF admission during the IRF's 12-month compliance review period. Note that the term "hospital patient number" used throughout this section refers to a unique patient identifier used internally within the hospital for patient identification and record-keeping purposes. For each inpatient on the list, the IRF must include the payer the IRF can bill, or has billed, for treatment and services furnished to the inpatient. If an inpatient on the list has multiple payers that the IRF can bill, or has billed, the IRF must include and specify each type of payer. In addition, for each inpatient on the list, the IRF must include the IRF admission and discharge dates.

Exception to the General Guideline: The Secretary of Health and Human Services can declare a Public Health Emergency under section 319 of the Public Health Service Act or another appropriate statute, and the President can declare either a National Emergency under the National Emergencies Act or a Major Disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, or other appropriate law. In accordance with such declarations, certain regulations or operational policies may be waived in specific geographic areas for limited and defined periods of time. If applicable, in accordance with the waiver provisions, the IRF may be permitted to admit patients (referred to in this section as national emergency or disaster inpatients) who otherwise would be admitted to another inpatient setting. The national emergency or disaster inpatients will not be included as part of the IRF's total inpatient population when the IRF's compliance with the requirements specified in §140.1.1B-D is determined by the *A/B MAC (A)* reading a sample of medical records. Therefore, when the IRF submits the list of hospital patient numbers stipulated above in section 140.1.3B3, the IRF will identify each national emergency or disaster inpatient by placing either the capital letter "E" or "D" after the patient's unique internal hospital identification number. The *A/B MAC (A)* will verify the information and, if appropriate, exclude these patients from the list of inpatients used to select a sample of medical records. The IRF should appropriately document in the medical record sufficient information to identify an inpatient as a national emergency or disaster inpatient.

4. The *A/B MAC (A)* will use the list of hospital patient numbers to determine the IRF's total inpatient population during the IRF's compliance review period. The *A/B MAC (A)* will then determine whether the compliance percentage threshold differs or is the same throughout the IRF's compliance review period.

If the compliance percentage threshold differs during the compliance review period (i.e., if it is 50 percent for one portion of the period and 60 percent for the other portion), then the *A/B MAC (A)* must determine that at least 50 percent of the IRF's total inpatient population consisted of Medicare Part A fee-for-service patients for both time periods. For example, the *A/B MAC (A)* will consider the portion of the period in which the compliance percentage threshold is 50 percent and the portion of the period in which the compliance percentage threshold is 60 percent independently and determine if the IRF's total inpatient population consists of at least 50 percent Medicare Part A fee-for-service patients in each of the two time periods.

If, however, the compliance percentage threshold is the same throughout the IRF's compliance review period (i.e., 60 percent throughout the period), then the *A/B MAC (A)* must determine that at least 50 percent of the IRF's total inpatient population consisted of Medicare Part A fee-for-service or Medicare Part C (Medicare Advantage) patients (beginning on or after October 1, 2009) for the entire 12-month period.

In addition to the above processes, the *A/B MAC (A)* has the discretion to sample and compare other parameters (that is, diagnoses, procedures, length-of-stay, or any other relevant parameter) to determine that the Medicare Part A fee-for-service and Medicare Part C (Medicare Advantage) population (beginning on or after October 1, 2009) is representative of the IRF's total inpatient population.

A determination by the *A/B MAC (A)*, in accordance with the preceding methodologies, that the IRF's inpatient population for the compliance review period consisted of at least 50 percent Medicare Part A fee-for-service and Medicare Part C (Medicare Advantage) patients (beginning on or after October 1, 2009) means that the *A/B MAC (A)* can use the procedure stipulated below in subsection C to presumptively determine if the IRF met the compliance threshold as specified above in §140.1.1B-D.

5. The *A/B MAC (A)* will inform the RO if an IRF fails to send the list showing the hospital patient number associated with each inpatient IRF admission during the most recent, consecutive, and appropriate 12-month period, as defined by CMS. Further, the *A/B MAC (A)* will inform the RO if the list of hospital patient numbers does not show the payer or payers or the admission and discharge dates for each hospital patient number on the list. The RO will notify the IRF that failure to send the *A/B MAC (A)* the list within an additional 10 calendar days will result in a determination by the RO that the IRF has not met the requirements specified above in §140.1.1B-D and the facility will no longer be eligible for payment under the IRF PPS.

C. - Verification of the Medical Condition Criteria Using the Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI) Data Records (The Presumptive Methodology)

1. To determine if a facility has presumptively complied with the criteria specified above in §140.1.1B-D, the CMS will enable the *A/B MAC (A)* to access the CMS' IRF-PAI data records. Specifically, each *A/B MAC (A)* will be allowed to access only the IRF-PAI information submitted by IRFs that submit claims to that *A/B MAC (A)*. In order to ensure that the software that matches each IRF to a particular *A/B MAC (A)* is constantly updated, the *A/B MAC (A)* must electronically send the RO a table that has at least the following title and column headings:

A/B MAC (A) List Of IRF Provider Numbers (Specify The *A/B MAC (A)*'s Name)

The Name of Each IRF That Submits Claims To This *A/B MAC (A)*	IRF Provider Number	IRF Cost Reporting Period

After checking the *A/B MAC (A)*'s list of IRFs for completeness and, as necessary, communicating with the *A/B MAC (A)* to ensure the accuracy of the information, the RO will forward the *A/B MAC (A)*'s list of IRFs to the CMS contractor that maintains the IRF-PAI database. The CMS contractor that maintains the IRF-PAI database will then, if necessary, update the IRF-PAI database software used to presumptively verify compliance with the requirements specified in §140.1.1B-D. The *A/B MAC (A)* must coordinate with their CMS RO to obtain access to the software system. The *A/B MAC (A)* will provide the RO with user information from all *A/B MAC (A)* staff that are required to access the IRF-PAI data records.

2. When the *A/B MAC (A)* accesses the IRF-PAI data records, the *A/B MAC (A)* will be able to generate an IRF compliance review report using the IRF-PAI information from the IRFs on the *A/B MAC (A)*'s list. The software that the *A/B MAC (A)* uses to generate the IRF compliance review report will automatically use the specific *diagnosis* and impairment group codes that are listed in Appendix B and Appendix C of the October 1, 2007 IRF Compliance Rule Specification Files, which can be downloaded from the IRF PPS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Criteria.html, to determine if a particular IRF is presumptively in compliance with the requirements specified in §140.1.1B-D. Prior to generating the IRF compliance review report, the *A/B MAC (A)* must allow the

IRF to decide whether the IRF compliance review report will be generated using the IRF-PAI data records of patients who were admitted during the IRF's compliance review period (even if they were discharged outside of the compliance review period), or the IRF-PAI data records of patients who were discharged during the IRF's compliance review period (even if they were admitted outside of the compliance review period).

Below are the sections of the IRF compliance review report with example data:

IRF Compliance Review Report

State	Provider Number	Provider Name	Cost Report Start Date	Compliance Review Period
Any State	IRF Number	Best Rehab	08/01/2008	04/01/2007 To 03/31/2008

Submitted Assessments	Eligible Assessments	Percent
100	60	60%

The submitted assessments section identifies all of the IRF-PAI data records that the IRF submitted to the IRF-PAI database during the compliance review period. The eligible assessments are the assessments submitted during the compliance review period that match one of the codes in Appendix B and Appendix C of the October 1, 2007 IRF Compliance Rule Specification Files, which can be downloaded from the IRF PPS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Criteria.html. The cost report start date shown is the start of the facility's next cost reporting period.

3. If an IRF's inpatient Medicare Part A fee-for-service and Medicare Part C (Medicare Advantage) populations (combined) (beginning on or after October 1, 2009) are at least 50 percent of its total inpatient population and the presumptive methodology (described above) indicates that the IRF met or exceeded the requirements specified in §140.1.1B-D, then the IRF is presumed to have met the requirements specified above in §140.1.1B-D. However, even when an IRF is presumed to have met the requirements specified above in §140.1.1B-D, the RO and *A/B MAC (A)* still have the discretion to instruct the IRF to send to the RO or *A/B MAC (A)* specific sections of the medical records of a random sample of inpatients, or specific sections of the medical records of inpatients identified by other means by the CMS or the *A/B MAC (A)*.

4. Each *A/B MAC (A)* must submit a report to the appropriate CMS RO (with a copy to the CMS Central Office) on at least a quarterly basis that shows each IRF's status with respect to compliance with the requirements specified above in §140.1.1B-D.

Appendix B and Appendix C of the October 1, 2007 IRF Compliance Rule Specification Files, which can be downloaded from the IRF PPS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Criteria.html ,
will be used to determine presumptive compliance with the requirements specified above in §140.1.1B-D.

D. - Verification of the Medical Condition Criteria Using the Inpatient Rehabilitation Facility's Total Inpatient Population (Medical Review Methodology)

1. The *A/B MAC (A)* must use the IRF's total inpatient population to verify that the IRF has met the requirements specified above in §140.1.1B-D if:

(i) the IRF's Medicare population (including Medicare Part A fee-for-service and Medicare Part C (Medicare Advantage) patients, effective October 1, 2009) is not at least 50 percent of its total inpatient population; or

(ii) the *A/B MAC (A)* is unable to generate a valid IRF compliance review report using the IRF-PAI database methodology specified previously; or

(iii) the *A/B MAC (A)* generates an IRF compliance review report, based on the use of the presumptive methodology, which demonstrates that the IRF has not met the requirements specified above in §140.1.1B-D.

If the IRF's Medicare Part A fee-for-service and Medicare Part C (Medicare Advantage) populations (combined, effective October 1, 2009) comprise less than 50 percent of the IRF's total inpatient population, or the *A/B MAC (A)* otherwise determines that the Medicare Part A fee-for-service and Medicare Part C (Medicare Advantage) populations (combined, effective October 1, 2009) are not representative of the overall IRF inpatient population, or the *A/B MAC (A)* is unable to generate a valid report using the presumptive methodology, the presumptive determination is that the IRF did not meet the requirements specified above in §140.1.1B-D.

2. As previously stated above, the *A/B MAC (A)* will instruct the IRF to send the *A/B MAC (A)* a list showing the hospital patient number of each inpatient that the IRF admitted during the most recent, consecutive, and appropriate 12-month period, as defined by CMS. The list of hospital patient numbers must include the payer(s) and admission and discharge dates that correspond with the inpatients whose hospital patient numbers are shown on the list. The *A/B MAC (A)* will then use generally accepted statistical sampling techniques to obtain a random sample of inpatients from the list. The random sample of inpatients drawn from the list must be sufficiently large to ensure that the *A/B MAC (A)* can determine, with at least 95 percent confidence, whether the IRF's compliance percentage is below the required compliance threshold (i.e., not in compliance) or at or above the required compliance threshold (i.e., in compliance).

For example, suppose that the required compliance threshold for an IRF to be in compliance with the requirements specified above in §140.1.1B-D is 60 percent. The *A/B MAC (A)* reviews a random sample of claims from IRF A and estimates that IRF A's compliance percentage is 58 percent. Suppose that the standard deviation that the *A/B MAC (A)* calculates for IRF A's random sample of IRF claims is plus or minus 4 percentage points, so that the 95 percent confidence interval in this particular example is between 54 percent and 62 percent (with 58 percent as the midpoint). In this case, the IRF is considered to be in compliance with the 60 percent rule, since 60 percent is within the 95 percent confidence interval. To verify whether the IRF is in fact in compliance with the requirements specified above in §140.1.1B-D, the *A/B MAC (A)* may need to draw a larger random sample of the IRF's inpatients. For example, a larger random sample of IRF A's inpatients might have reduced the standard deviation to plus or minus 1 percentage point, which would have led the 95 percent confidence interval to be between 57 percent and 59 percent. This would have demonstrated with 95 percent confidence that the IRF was not in compliance with the requirements specified above in §140.1.1B-D (because the entire 95 percent confidence interval was below the required compliance threshold of 60 percent).

If the compliance percentage threshold differs within the compliance review period (i.e., is 50 percent for a portion of the compliance review period and 60 percent for the other portion of the period), then a random sample of inpatients will be drawn from each of the two time periods separately.

The use of generally recognized statistical sampling principles may result in a determination that it would be inappropriate to use a sample to determine the facility's compliance percentage. If a random

sample is not appropriate in a particular case, then the *A/B MAC (A)* will use the IRF's entire inpatient population to determine the IRF's compliance percentage. In addition, if the IRF had 100 or fewer inpatients during the compliance review period, then the *A/B MAC (A)* must use the IRF's total inpatient population (consisting of both Medicare and non-Medicare inpatients) to determine the IRF's compliance percentage.

Prior to selecting the random sample of inpatients, the *A/B MAC (A)* must allow the IRF to decide if the IRF wants the sample to contain either the patients who were admitted during the IRF's compliance review period (even if some of those patients were discharged outside of the compliance review period) or the patients discharged during the IRF's compliance review period (even if some of those patients were admitted outside of the compliance review period).

If the *A/B MAC (A)* uses a random sample of the IRF's inpatient population (rather than the IRF's total inpatient population) to determine the IRF's compliance percentage, then the *A/B MAC (A)* must ensure that an adequate sample size is used to determine (with at least a 95 percent statistical level of confidence) whether or not the IRF has met the requirements in §140.1.1B-D. In some cases, this will require the *A/B MAC (A)* to expand the size of the random sample of inpatients selected from a particular IRF.

The *A/B MAC (A)* will instruct the IRF to send it copies of specific sections of the medical records for all of the inpatients to be used in the compliance review. The *A/B MAC (A)* has the discretion to decide which specific sections of the medical records to obtain, provided that the requested medical record sections contain enough information to allow the *A/B MAC (A)*'s reviewers to determine the medical condition(s) for which each inpatient received treatment in the IRF. In addition to submitting the requested sections of the medical records, the IRF has the discretion to send the *A/B MAC (A)* other clinical information regarding these same inpatients.

3. The *A/B MAC (A)* will examine the medical record sections and any other information submitted by the IRF to determine if the IRF meets the requirements specified above in §140.1.1B-D. To determine if a specific inpatient matches one of the medical conditions specified in §140.1.1C, the *A/B MAC (A)* may use the *diagnosis* and impairment group codes specified in Appendix B and Appendix C of the most recent IRF Compliance Rule Specification Files (which can be downloaded from the IRF PPS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Criteria.html) for general guidance. However, the *A/B MAC (A)* is not permitted to use these codes to make a final determination as to whether or not the specific inpatient required intensive rehabilitation services for treatment of one or more of the medical conditions specified in §140.1.1C. The determination of whether a specific inpatient required intensive rehabilitation services for treatment of a condition can only be determined through careful review of that inpatient's unique clinical characteristics and circumstances, as reflected in the inpatient's medical record.

4. In general, when the *A/B MAC (A)* is using a sample of medical records to determine compliance with the requirements in §140.1.1B-D, the *A/B MAC (A)* always has the discretion to determine if a patient meets or does not meet any of the medical conditions listed in §140.1.1C based upon a review of the clinical record, regardless of the results of the presumptive methodology described previously. In other words, the compliance percentage that is determined using the medical review methodology described in this section will supersede the compliance percentage that was determined for the same compliance review period using the presumptive methodology. To ensure that the compliance review process is similar for all IRFs, the *A/B MAC (A)* must have written policies that describe the reasons for using a random sample of medical records to determine an IRF's compliance percentage when the presumptive methodology has shown that the IRF met the compliance threshold.

5. The *A/B MAC (A)* will inform the RO if an IRF fails to provide information in accordance with the requirements specified above in subsection D2. The RO will notify the IRF that failure to provide the *A/B MAC (A)* with the information in accordance with the requirements specified above in subsection D2

will result in a determination by the RO that the IRF has not met the requirements specified above in §140.1.1B-D.

E. - By the 15th day of each month, the *A/B MAC (A)* responsible for determining the compliance percentage for each IRF using either of the methods specified above in §§140.1.3C or 140.1.3D will submit a report to CMS via e-mail. Instructions regarding the format of the report, how to complete the report, and where to send it are specified on the IRF PPS website at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Criteria.html .

F. - The *A/B MAC (A)* must verify that the requirements specified above in §140.1.1B-E and §140.1.2 G-K were met.

G. - The State Agency will determine whether the criteria specified above in §140.1.1F-K and §140.1.2 Q were met.

140.3 - Billing Requirements Under IRF PPS

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD -10, Implementation: ICD -10: Upon Implementation of ICD -10, ASC X12: September, 23 2014)

IRF PPS payment is contingent on the requirement that IRFs complete a patient assessment upon admission and discharge for Medicare patients. The August 7, 2001, Final Rule, and subsequent final rules contain detailed information regarding the assessment schedule for the patient assessment instrument (PAI) with respect to transmission requirements, encoding dates, and other pertinent information. Further, there is an item-by-item guide, which specifies detailed instructions regarding the manner in which each item on the assessment instrument needs to be completed.

Effective with cost reporting periods beginning on or after January 1, 2002, IRFs are required to report billing data with a new revenue code and a Health Insurance PPS (HIPPS) Rate Code on *the ASC X12 837 institutional claim or, in rare cases, on the* Form *CMS-*1450 for all Part A inpatient claims (Type of Bill 11X) to their *A/B MACs (A)*. The new revenue code, 0024, is used in conjunction with the HIPPS Rate Code to identify the CMG payment classification for the beneficiary. In addition to all entries previously required on a Part A claim, the following additional instructions must be followed to accurately price and pay a claim under the IRF PPS. These claims must be submitted on Type of Bill 11X. The last four digits of the provider number for rehabilitation hospitals is from 3025 to 3099, and for rehabilitation distinct part units the third digit will be a T if the unit is located in an acute care hospital or an R if the unit is located in a CAH.

- The Revenue code must contain revenue code 0024. This code indicates that this claim is being paid under the PPS. This revenue code can appear on a claim only once.

- The following Patient Discharge Status codes are applicable under the transfer policy for IRF PPS: 02, 03, 61, 62, 63, and 64.

NOTE: IRFs that transfer a beneficiary to a nursing home that accepts payment under Medicare and/or Medicaid should use PS 03, discharged/transferred to a SNF. IRFs that transfer a beneficiary to a nursing facility that does not accept Medicare or Medicaid, should code PS 04, discharged/transferred to an ICF, until such time that a new PS code is established to differentiate between nursing facilities that do not accept Medicare and/or Medicaid and those that do. PS 04 does not constitute a transfer under the IRF PPS policy.

- For typical cases, the HCPCS/Rates must contain a five digit HIPPS Rate/CMG Code (AXXYY-DXXYY). The first position of the code is an A, B, C, or D. The HIPPS rate code beginning with A in front of the CMG is defined as without comorbidity. The HIPPS rate code containing a B in front of the CMG is defined as with comorbidity for Tier 1. The HIPPS rate code containing a C in front of the CMG is defined as with comorbidity for Tier 2. The HIPPS rate code containing a D in front of the CMG is defined as with comorbidity for Tier 3. The (XX) in the HIPPS rate code is the

Rehabilitation Impairment Category (RIC). The (YY) in the HIPPS rate code is the sequential numbering system within the RIC.

- For atypical cases effective January 1, 2010, the HCPCS/Rates must contain a five digit HIPPS Rate/CMG Code A5001. An atypical case occurs under the new IRF coverage requirements that became effective January 1, 2010, where an IRF is eligible to receive the IRF short stay payment for 3 days or less (HIPPS Rate/CMG A5001) if a patient's thorough preadmission screening shows that the patient is an appropriate candidate for IRF care but then something unexpected happens between the preadmission screening and the IRF admission such that the patient is no longer an appropriate candidate for IRF care on admission and the day count is greater than 3. In this scenario only, if the patient is discharged/transferred on or after day 4, we are instructing IRFs to bill HIPPS Rate/CMG A5001. Thus, whether or not the IRF is able to discharge the patient to another setting of care within 3 days, the IRF will only be eligible for and receive the IRF short stay payment for 3 days or less (HIPPS Rate/CMG A5001).

Covered Charges should contain zero covered charges when the revenue code is 0024. For accommodation revenue codes (010x-021x), covered charges must equal the rate times the units. The IRF Pricer will calculate and return the payment amount for the line item with revenue code 0024. Non-outlier payments will not be made based on the total charges shown in Revenue Code 0001.

- IRF providers will submit one admit through discharge claim for the stay. Final PPS payment is based upon the discharge bill.

- Should the patient's stay overlap the time in which the PPS applies to the facility, PPS payment will still be based on discharge. If the facility submitted an interim bill, a debit/credit adjustment must be made prior to PPS payment. If the facility submits multiple interim bills, the provider will need to submit cancels and then rebill once the cancels are accepted.

- IRFs can submit adjustment bills (even to correct the CMG), but late charge bills will not be allowed (Type of bill 115).

- If a beneficiary has 1 day of Medicare coverage during their IRF stay, an entire CMG payment will be made.

- IRFs will be paid under the IRF PPS beginning on the first day of their cost reporting period that begins on or after January 1, 2002. Units established in a CAH will be paid under the IRF PPS beginning with CAH cost reporting periods on or after October 1, 2004.

For interim bills, if the stay is greater than 60 days, the interim bill should include the lowest level of the HIPPS code from the admission assessment. The final claim will be adjusted to reflect data from the discharge assessment.

When coding PPS bills for ancillary services associated with a Part A inpatient stay, the traditional revenue codes will continue to be shown, e.g., 0250 - Pharmacy, 042x - Physical Therapy, in conjunction with the appropriate entries in Service Units and Total Charges.

- IRFs are required to report the number of units based on the procedure or service.

- IRFs are required to report the actual charge for each line item, in Total Charges.

If a beneficiary's Part A benefits exhaust during the stay, code an occurrence code A3-C3. If benefits are exhausted prior to the stay, submit a no pay claim, which will be coded by the *A/B MAC (A)* with no pay code B. Report any services that can be billed under the Part B benefit using 12X TOB.

NOTE: For more information on outlier payments when benefits are exhausted, please see §20.7.4. Although this references an expired instruction specific to inpatient hospital PPS billing, the information presented provides important general information. Should this situation occur in an IRF, IRF providers may apply this same type of logic and an IRF PC Pricer will be made available for assistance.

140.3.3 - Remittance Advices

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD -10, Implementation: ICD -10: Upon Implementation of ICD -10, ASC X12: September, 23 2014)

A remittance advice remark code is used to notify an IRF when the CMG code was changed: N100 *PPS (Prospective Payment System)* code corrected during adjudication.

Existing reason and remark codes are used in remittance advice transactions to explain other adjustments made to the claim during adjudication.

Providers receiving the Electronic Remittance Advice (ERA) will receive the CMG code under which payment is made in the service level procedure code field. If the CMG is *modified during adjudication, the paid under CMG, will be reported at the service level. Providers that receive paper RAs, will not receive service level details.*

Existing Medicare Summary Notices and Notices of Utilization for beneficiaries are appropriate for IRF PPS claims.

150.7 - Patient Classification System

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD -10, Implementation: ICD -10: Upon Implementation of ICD -10, ASC X12: September, 23 2014)

The BBRA required the use of diagnostic-related groups (DRGs) for patient classification purposes in the PPS for LTCHs. In general, a case is grouped based on the clinical characteristics of the Medicare beneficiary.

The patient classification system groupings are called LTC-DRGs, which are based on the existing CMS DRGs used under the acute care hospital inpatient PPS. Patient discharges are grouped using ICD *diagnosis* codes *reported on the claim for* the principal diagnosis, up to *twenty four* additional diagnoses, and up to *twenty five* procedures performed during the stay, as well as age, sex, and discharge status of the patient.

The same GROUPER software developed by 3M for the acute care hospital inpatient PPS, is used but with LTCH-specific relative weights reflecting the resources used to treat the medically complex LTCH patients).

150.12.1 - Processing Bills Between October 1, 2002, and the Implementation Date

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD -10, Implementation: ICD -10: Upon Implementation of ICD -10, ASC X12: September, 23 2014)

Claims submitted prior to implementation were processed under the current methodology. On or after January 1, 2003, submit mass adjust claims under the PPS payment methodology by April 30, 2003. The shared systems is creating a mass adjustment program.

Beginning October 16, 2003, all LTCHs are required to comply with the HIPAA Administrative Simplification Standards, unless they have obtained an extension in compliance with the Administrative Compliance Act to submit claims in compliance with the standards at 42 CFR 162.1002 and 45 CFR 162.1192 using the ICD. All ICD coding must be used for LTCH providers with cost reporting period beginning on or after October 1, 2002.

150.13 - Billing Requirements Under LTCH PPS

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD -10, Implementation: ICD -10: Upon Implementation of ICD -10, ASC X12: September, 23 2014)

Billing LTCH PPS Services

Effective with cost reporting periods beginning on or after October 1, 2002, LTCHs are to incorporate the following so that *A/B MACs (A)* accurately price and pay a claim under the LTCH PPS. These claims must be submitted on Type of Bill 11X.

This is a DRG- based payment system; therefore the LTCH DRG is determined by the grouping of *diagnosis codes reported on the claim for the* principal diagnosis, up to *twenty four* additional diagnoses, and up to *twenty five* procedures performed during the stay, as well as age, sex, and discharge status of the patient on the claim. Grouper software will determine DRG assignment.

Each bill from an LTCH must contain the complete diagnosis and procedure coding for purposes of the GROUPER software. Normal adjustments will be allowed. LTCH providers submit one admit through discharge claim for the stay. Final PPS payment is based upon the discharge bill (note that the day in which benefits exhaust is considered a "discharge" for payment purposes).

Effective December 3, 2007, once a patient's Medicare benefit's exhaust, the LTCH is allowed to submit no-pay bills until physical discharge or death.

150.16 - Billing Ancillary Services Under LTCH PPS

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD -10, Implementation: ICD -10: Upon Implementation of ICD -10, ASC X12: September, 23 2014)

When coding PPS bills for ancillary services associated with a Part A inpatient stay, the traditional revenue codes are shown, in conjunction with the appropriate entries in Service Units and Total Charges.

- LTCHs are required to report the number of units based on the procedure or service.
- LTCHs are required to report the actual charge for each line item, in Total Charges.
- In general the current policy applies for billing ancillary services and nothing changes with the implementation of this PPS.

160.1.1 - Identifying Claims Eligible for the Add-On Payment for New Technology

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD -10, Implementation: ICD -10: Upon Implementation of ICD -10, ASC X12: September, 23 2014)

Technologies eligible for add-on payments are identified based on the applicable codes from the International Classification of Diseases, Clinical Modification. Claims submitted with an ICD code indicating that a new technology was involved in the treatment of the patient is then eligible for add-on payments as described above.

The system maintainers pass (if present) the "principal" and up to twenty four "other procedure" codes to PRICER. If an eligible code is present, PRICER calculates an add-on payment if appropriate.

Additionally, the National Uniform Billing Committee has approved value code 77 *for use on the ASC X12 837 institutional claim or Form* CMS-1450 for *A/B MAC (A)* use only, defined as "New Technology Add-On Payment." This value code must be passed to CWF and the PS&R. The amount shown in this value code must be paid to PIP providers on a claim-by-claim basis the same as outlier payments are paid to PIP providers.

170.1.3 - Completion of the Notice of Election for RNHCI

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD -10, Implementation: ICD -10: Upon Implementation of ICD -10, ASC X12: September, 23 2014)

Elections, revocations and cancellations of elections may be submitted to the contractor via the paper *Form CMS-1450* or via the contractor's Direct Data Entry (DDE) system. Election transactions are not covered transaction under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and therefore the HIPAA standard claim transaction is not required. Additionally, the HIPAA standard claim transaction (ASC X12 837 *institutional* claim format) does not support the data requirements of these transactions.

This section gives detailed information only for items required for the notice of election and related transactions. The RHNCI does not need to complete items not listed.

Provider Name, Address, and Telephone Number

Required - The minimum entry is the RNHCI's name, city, State, and ZIP code. The post office box number or street name and number may be included. The State may be abbreviated using standard post office abbreviations. Five- or 9-digit ZIP codes are acceptable. The RNHCI uses the information to reconcile provider number discrepancies. Phone and/or FAX numbers are desirable.

Type of Bill

Required - The RNHCI enters the 3-digit numeric type of bill code. The first digit identifies the type of facility. The second digit classifies the type of care. The third digit (commonly referred to as a "frequency" code) indicates in this instance the nature of the election related transaction.

The RNHCI enters type of bill 41A, 41B, or 41D as appropriate.

Valid codes for RNHCI elections:

1st Digit - Type of Facility

4- Religious Nonmedical Health Care Institution

2nd Digit - Classification (Special Facility)

1- Inpatient (Part A)

3rd Digit – Frequency

A - RNHCI election notice

B - RNHCI revocation notice

D – Cancellation

The RNHCI submits type of bill 41D to the specialty contractor as a cancellation of a previously submitted notice of election or notice of revocation, when it was submitted in error. In situations where the RNHCI is correcting a previously submitted date, they submit a new type of bill 41A to the contractor for processing.

Patient's Name

Required - The RNHCI enters the patient's name with the surname first, first name, and middle initial, if any.

Patient's Address

Required - The RNHCI enters the patient's full mailing address including street name and number, post office box number or RFD, city, State, and ZIP code.

Patient's Birth Date

Required - (If available) The RNHCI enters the month, day, and year of birth. If the date of birth cannot be obtained after a reasonable effort, the field will be zero-filled.

Patient's Sex

Required - The RNHCI enters an "M" for male or an "F" for female.

Admission Date

Required - The RNHCI enters the date of the election, revocation or cancellation. In no instance should the date be prior to July 1, 2000.

National Provider Identifier

Required – The RNHCI enters their National Provider Identifier (NPI). During Medicare processing, the NPI is matched to the RHNCI's CMS Certification Number (CCN). RNHCI CCNs are composed of a 2-digit state code and a 4-digit provider identifier in the range 1990-99.

Insured's Name

Required - The RNHCI enters the beneficiary's name on line A if Medicare is the primary payer. The RNHCI enters the name as on the beneficiary's Medicare card. If Medicare is the secondary payer, the RNHCI enters the beneficiary's name on line B or C, as applicable, and enters the insured's name on line A.

Insured's Unique Identification

Required - On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information is, the RNHCI enters the patient's HICN. The RNHCI enters the number as it appears on the patient's Medicare Card, Social Security Award Certificate, Utilization Notice, Medicare Summary Notice, Temporary Eligibility Notice, etc., or as reported by the Social Security Office.

170.2.2 - Required Data Elements on Claims for RNHCI Services

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD -10, Implementation: ICD -10: Upon Implementation of ICD -10, ASC X12: September, 23 2014)

The Social Security Act at §1862 (a)(22) requires that all claims for Medicare payment must be submitted in an electronic form specified by the Secretary of Health and Human Services, unless an exception described at §1862 (h) applies. The electronic form required for billing RNHCI claims is the *ASC X12 837 institutional* claim transaction. Since the data structure of the *ASC X12* 837 *institutional claim* transaction is difficult to express in narrative form and to provide assistance to small providers excepted from the electronic claim requirement, the instructions below are given relative to the Form CMS-1450 paper claim.

Both the electronic claim transaction and the paper claim form are suitable for use in billing multiple third party payers. This section details only those data elements required for Medicare billing. When RNHCIs are billing multiple third parties, they complete all items required by each payer who is to receive a claim for the services.

Provider Name, Address, and Telephone Number

Required - The RNHCI must enter their name, city, State, and ZIP Code. The post office box number or street name and number may be included. The State may be abbreviated using standard post office abbreviations. Five or 9-digit ZIP Codes are acceptable. This information is used in connection with the Medicare provider number to verify provider identity. Phone/Fax numbers are desirable.

Patient Control Number/Medicare Record Number

Optional - The RNHCI may report a beneficiary's control number if they assign one and need it for association and reference purposes.

Type of Bill

Required - This 3-digit alphanumeric code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this claim in this particular episode of care. It is a "frequency" code.

Valid codes for RNHCI claims:

1st Digit-Type of Facility

4 - Religious Nonmedical Health Care Institution

2nd Digit Classification (Except Clinics and Special Facilities)

1 - Inpatient (Part A)

3rd Digit-Frequency	**Definition**
0-Nonpayment/zero claims	Use when you do not anticipate payment from the payer for the bill but are merely informing the payer about a period of nonpayable confinement or termination of care. The "Through" date of this bill is the discharge date for this confinement. Nonpayment bills are required only to extend the "spell of illness." See code 71 below.
l-Admit Through Discharge Claims	Use for a bill encompassing an entire inpatient confinement for which you expect payment from the payer or for which Medicare utilization is chargeable.
2-Interim-First Claim	Use for the first of an expected series of payment bills for the same confinement or course of treatment for which Medicare utilization is chargeable.
3-Interim-Continuing Claim	Use when a payment bill for the same confinement or course of treatment has been submitted, further bills are expected to be submitted and Medicare utilization is chargeable.
4-Interim-Last Claim	Use for a payment bill which is the last of a series for this confinement or course of treatment when Medicare utilization is chargeable. The "Through" date of this bill is the discharge date for this confinement.

7-Replacement of Prior Claim	Use to correct (other than late charges) a previously submitted bill. This is the code applied to the corrected or "new" bill.
8-Void/Cancel of a Prior Claim	This code indicates the bill is an exact duplicate of an incorrect bill previously submitted. Enter a code "7" (Replacement of Prior Claim) showing the correct information.

Statement Covers Period (From - Through)

Required - The RNHCI must enter the beginning and ending dates of the period covered by this bill. Enter the date of discharge or the date of death in the space provided under "Through." The statement covers period may not span 2 accounting years.

Patient's Name

Required - The RNHCI must enter the beneficiary's last name, first name, and middle initial, if any.

Patient's Address

Required - The RNHCI must enter the beneficiary's full mailing address, including street number and name, post office box number or RFD, City, State, and ZIP Code.

Patient Birth Date

Required - The RNHCI must enter the month, day, and year of birth (MM-DD-YYYY) of the beneficiary.

Sex

Required - The RNHCI must enter an “M” for male or an “F” for female.

Admission Date

Required - The RNHCI must enter the date the beneficiary was admitted for inpatient care.

(MM-DD-YY).

Type of Admission

Required - The RNHCI must enter the code indicating the priority of this admission.

Valid codes for RNHCI claims:

3	Elective	The beneficiary's condition permitted adequate time to schedule the availability of a suitable accommodation.
9	Information Not Available	Self-explanatory

Point of Origin for Admission

Required - The RNHCI must enter the code indicating the beneficiary’s point of origin. The RNHCI may use any valid point of origin code that applies to the particular admission.

Patient Discharge Status

Required - The RNHCI must enter the code indicating the patient's status as of the "Through" date of the billing period. The RNHCI may use any valid patient status code that applies to the discharge.

Condition Codes

Conditional - The RNHCI may enter any number of condition codes to describe conditions that apply to the billing period. If the RNHCI is submitting an adjustment or a cancellation claim, an applicable condition code from the 'claim change reason' series (D0 through D9 or E0) must be used.

If non-covered days are reported because the beneficiary's inpatient benefits were exhausted, the RHNCI must indicate whether the beneficiary elects to use lifetime reserve days. The RNHCI must indicate lifetime reserve days are used on the claim by reporting condition code 68. If the beneficiary elects not to use lifetime reserve days, the RNHCI must report condition code 67.

Occurrence Codes and Dates

Conditional - The RNHCI may enter any number of occurrence codes and their associated dates to define specific event(s) relating to this billing period. Occurrence codes are 2 alphanumeric digits, and are reported with a corresponding date.

If non-covered days are reported due to days not falling under the guarantee of payment provision, the RNHCI reports occurrence code 20.

If non-covered days are reported because the beneficiary's inpatient benefits were exhausted, the RNHCI reports occurrence code A3.

Occurrence Span Code and Dates

Conditional - The RNHCI may enter any number of occurrence span codes and their associated dates to define specific event(s) relating to this billing period. Occurrence span codes are 2 alphanumeric digits, and are accompanied by from and through dates for the period described by the code.

If non-covered days are reported because the beneficiary was on a leave of absence and was not in the RNHCI, the RNHCI reports occurrence span code 74.

Document Control Number (DCN)

Conditional - The RNHCI must complete this field on adjustment requests (Bill Type, 417). An RNHCI requesting an adjustment to a previously processed claim must insert the ICN/DCN of the claim to be adjusted.

Value Codes and Amounts

Required – The RNHCI must report utilization days using the value codes described below.

Covered Days - The RNHCI must use value code 80 to enter the total number of covered days during the billing period, including lifetime reserve days elected for which Medicare payment is requested. Covered days exclude any days classified as non-covered, the day of discharge, and the day of death.

Covered days are always in terms of whole days rather than fractional days. As a result, the covered days do not include the day of discharge, even where the discharge was late.

The RNHCI does not deduct any days for payment made under workers' compensation, automobile medical, no-fault, liability insurance, or an EGHP for an ESRD beneficiary or employed beneficiaries and spouses age 65 or over. The specialty contractor will calculate utilization based upon the amount Medicare will pay and will make the necessary utilization adjustment.

Non-covered Days - The RNHCI must use value code 81 to enter the total number of non-covered days in the billing period for which the beneficiary will not be charged utilization for Part A services. Non-covered days include:

- Days not falling under the guarantee of payment provision. See section 40.1. E.
- Days not approved by the utilization review committee when the beneficiary does not meet the need for Part A services;
- Days for which no Part A payment can be made because benefits are exhausted. This means that either lifetime reserve days were exhausted or the beneficiary elected not to use them.
- Days for which no Part A payment can be made because the services were furnished without cost or will be paid for by the VA. (Pub. 100-02, Medicare Benefit Policy Manual, Chapter 16, Section 50);
- Days after the date covered services ended, such as non-covered level of care;
- Days for which no Part A payment can be made because the beneficiary was on a leave of absence and was not in the RNHCI. See section 40.2.6;
- Days for which no Part A payment can be made because an RNHCI whose provider agreement has terminated may only be paid for covered inpatient services during the limited period following such termination. All days after the expiration of this period are non-covered. See Pub. 100-01, Medicare General Information, Eligibility and Entitlement Manual, Chapter 5, Section 10.6.4;

The RNHCI enters in "Remarks" a brief explanation of any non-covered days not described in the occurrence codes. Show the number of days for each category of non-covered days (e.g., "5 leave days").

Day of discharge or death is not counted as a non-covered day. All hospital inpatient rules for billing non-covered days apply to RNHCI claims.

Coinsurance Days - The RNHCI must use value code 82 to enter the number of covered inpatient days occurring after the 60th day and before the 9lst day for this billing period.

Lifetime Reserve Days - The RNHCI must use value code 83 to enter the number of lifetime reserve days the beneficiary elected to use during this billing period.

Lifetime reserve days are not charged where the average daily charge is less than the lifetime reserve coinsurance amount. The average daily charge consists of charges for all covered services furnished after the 90th day in the benefit period and through the end of the billing period.

The RNHCI must notify the beneficiary of their right to elect not to use lifetime reserve days before billing Medicare for services furnished after the 90th day in the spell of illness. The determination to elect or withhold use of lifetime reserve days should be documented and kept on file at the provider.

Conditional - The RNHCI may at their option enter any number of other value codes and related dollar amount(s) to identify data necessary for the processing of this claim. Value codes are 2 alphanumeric digits, and a corresponding value amount. Negative amounts are never shown. If more than one value code is shown for a billing period, the RNHCI must show codes in ascending numeric sequence.

Revenue Code

Required - The RNHCI must enter the appropriate revenue codes to identify specific accommodation and/or ancillary charges. This code takes the place of fixed line item descriptions. The 4-digit numeric revenue code on the adjacent line explains each charge. The following revenue codes and associated descriptions are used where there are charges billed as covered by Medicare:

Code	Description
0001	Total Charges
0120	Semi-Private Room
0270	Supplies (non-religious, as covered by Medicare)

Any other revenue codes may be submitted with non-covered charges only.

Additionally, there is no fixed "Total" line in the charge area. On paper claims, the RNHCI must enter revenue code "000l" to report a total of the charges on the claim.

The RNHCI should list revenue codes other than revenue code “0001” in ascending numeric sequence and should not repeat revenue codes on the same claim to the extent possible.

Units of Service

Required - The RNHCI must enter the number of days for accommodations revenue codes.

Accommodation days are always in terms of whole days rather than fractional days. The accommodation days do not include the day of discharge, even where the discharge was late. Where a charge was made because the beneficiary remained in the RNHCI after checkout time for his own convenience, it is a non-covered charge and you can bill the beneficiary if that is your usual practice and if the beneficiary is given proper notice of their liability. In this instance, the RNHCI will enter the additional charge in non-covered charges.

Total Charges

Required - The RHNCI must sum the total charges (covered and non-covered) for the billing period by revenue code and enter them on the adjacent line. On paper claims, the last revenue code entered in revenue code "000l" represents the grand total of all charges billed. For all lines, the total charges minus any associated non-covered charges represent the covered charges.

Each line allows up to 9 numeric digits (0000000.00).

When submitting charges (covered/non-covered):

- Medicare is restricted by law and court order from paying for the religious portion of care or the training of personnel that provide that care. Additionally Medicare does not pay either based on charges or costs for training of nonmedical personnel. RNHCIs do not receive full Medicare payment for a beneficiary’s stay since the beneficiary is fiscally responsible for the religious aspects of care. Therefore, the original Medicare or Medicare health plan rate may be significantly lower than the RNHCI private pay rate that includes religious charges.

- As medical procedures are not performed in a RNHCI, the use of high cost medical supplies are not separately payable. Supplies that require a physician order (e.g., specialty dressings, compression stockings, alternating pressure mattress pads) are not separately payable in a RNHCI. The use of

diapers, incontinence pads, chux/underpads, feminine hygiene products, tissues, and the materials for simple dressings (cleansing and bandaging) are included in the daily room and board portion of the charges and should not be reported separately as supplies.

- Medical equipment (e.g., wheelchair, walker, crutches) are institution inventory items for beneficiary use in the RNHCI. The use of these items during the beneficiary stay is part of the daily interim payment to the RNHCI. To receive Medicare payment for durable medical equipment (DME) following a RNHCI stay, a beneficiary would need to meet all of the criteria, including medical necessity, and obtain a physician order or prescription. A RNHCI is not authorized as a Medicare supplier and, therefore, may not offer DME items for purchase to beneficiaries.

- Nonmedical nursing personnel, for Medicare payment purposes, perform services (e.g., serving meals, assisting with activities of daily living) that are strictly nonmedical/non-religious. The statute and court order mandates only the coverage and payment under Part A for reasonable and necessary nonmedical/non-religious care.

- Medicare payment for religious/nonmedical nursing personnel in a RNHCI, as other inpatient facilities, is a component of the per diem rate and is not separately payable.

Non-Covered Charges

Required - The RHNCI must enter the total non-covered charges pertaining to the related revenue code, if any (e.g., religious items/services or religious activities performed by nurses or other staff, or convenience items that are not part of the Medicare daily interim payment rate.)

Examples of non-covered charges:

- Non-covered religious items include but are not limited to religious publications, religious recordings, any equipment for the use of those recordings, any reproduction costs for these materials, and attendance at religious meetings.

- Religious sessions with RNHCI staff or outside associates.

- Expenses related to student programs/subsistence, staff education/training, travel, or relocation to be factored into the development of charges for covered patient care services.

- Stays, items, and services that are not substantiated by appropriate documentation in the beneficiary's utilization review file or care record.

- Convenience items (e.g., telephone, computer, beautician/barber).

Payer Identification

Required - If Medicare is the primary payer, the RNHCI must enter "Medicare" on line A. If Medicare is entered, this indicates that the RNHCI has developed for other insurance and has determined that Medicare is the primary payer.

All additional entries across line A supply information needed by the payer named. If Medicare is the secondary or tertiary payer, the RNHCI may identify the primary payer on line A and enter Medicare information on line B or C as appropriate.

National Provider Identifier

Required – The RNHCI enters their National Provider Identifier (NPI). During Medicare processing, the NPI is matched to the RHNCI's CMS Certification Number (CCN). RNHCI CCNs are composed of a 2-digit state code and a 4-digit provider identifier in the range 1990-99.

Insured's Unique Identification

Required - On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information is shown, the RNHCI must enter the beneficiary's Medicare Health Insurance Claim Number. The RNHCI must show the number as it appears on the beneficiary's Medicare Card, Certificate of Award, Utilization Notice, Medicare Summary Notice, Temporary Eligibility Notice, or as reported by the Social Security Office.

Principal Diagnosis Code

Required - While coding of a principal diagnosis is not consistent with the nonmedical nature of RNHCI services, the presence of diagnosis codes is a requirement for claims transactions under HIPAA. To satisfy this requirement on claims with Statement Covers "Through" dates *before implementation of ICD-10,* the RNHCI may report ICD-9 code 799.9 (defined "other unknown and unspecified cause"). To satisfy this requirement on claims with Statement Covers "Through" dates on or after *the implementation of ICD-10*, the RNHCI may report ICD-10 code R69 (defined "illness, unspecified").

Other Diagnosis Codes

Required - While coding of diagnoses is not consistent with the nonmedical nature of RNHCI services, the presence of diagnosis codes is a requirement for claims transactions under HIPAA. To satisfy this requirement on claims with Statement Covers "Through" dates *before the implementation of ICD-10*, the RNHCI may report ICD-9 code V62.6 (defined "refusal of treatment for reasons of religion or conscience"). To satisfy this requirement on claims with Statement Covers "Through" dates on or after the *implementation of ICD-10*, the RNHCI may report ICD-10 code Z53.1 (defined "procedure and treatment not carried out because of patient's decision for reasons of belief").

The RNHCI reports no additional diagnosis codes in the remaining fields. Similarly, RNHCIs do not use other fields relating to medical diagnoses and medical procedures.

Attending Provider

Required – While the participation of an attending provider is not consistent with the nonmedical nature of RNHCI services, reporting an attending provider is a requirement for claims transactions under HIPAA. To satisfy this requirement, the RNHCI must report the name and NPI of their director of nursing.

Remarks

Conditional - The RNHCI may enter any remarks needed to provide information that is not shown elsewhere on the bill but which is necessary for proper payment.

Provider Representative Signature and Date

Required – If using the hard copy claim, an RNHCI representative makes sure the claim record is complete and accurate before signing Form CMS-1450. A stamped signature is acceptable on Form CMS-1450.

180.1 - Recording Determinations of Excepted/Nonexcepted Care on Claim Records

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD -10, Implementation: ICD -10: Upon Implementation of ICD -10, ASC X12: September, 23 2014)

Once the excepted/nonexcepted care determination is made, the non-specialty contractor resubmits the claim to CWF using the following indicators to record the determination:

- Indicator "1" - for excepted care; or
- Indicator "2" - for nonexcepted care.

NOTE: Indicator 0 (zero) presents no entry.

The following are the fields and locations for the excepted and nonexcepted indicators on the CWF record types:

Record	Location	Field	Size
HUIP (IP hospital/SNF Claim)	84	1	823
HUOP (Outpatient)	64	1	778
HUHC (Hospice)	64	1	778
HUHH (Home Health)	64	1	778
HUBC (*A/B MAC (B)* Claim)	13	1	57

The screen field corresponding to these CWF fields may vary depending on the Medicare shared system in use at a contractor's location. Non-specialty contractors may contact their shared system maintainer if necessary to determine the correct screen location to use for excepted/nonexcepted care indicators.

If a claim is resubmitted with a "0" excepted care indicator in error, CWF will again reject the claim. Upon receipt of the resubmitted claim with a valid "1" or "2" entry, CWF will approve it for payment and revoke the beneficiary's election if the care received was nonexcepted. CWF will **not** notify either the specialty contractor or the non-specialty contractor of any revocations as a result of claims received for nonexcepted care. Any subsequent RNHCI claims processed at the contractor with RNHCI specialty workload will be not approved for payment by CWF unless the beneficiary files a new election following the prescribed time intervals between elections.

If development to make the excepted/nonexcepted care determination discovered that the beneficiary paid out of pocket for the services and the claim for payment for medical care must be denied as a result, annotate the claim and the associated remittance advice with the following codes:

- Claim adjustment reason code *96, defined "Noncovered charges."* Additional information is supplied using the remittance advice remarks codes whenever appropriate."
- Remittance advice remark code MA47, defined "Our records show you have opted out of Medicare, agreeing with the patient not to bill Medicare for services/tests/supplies furnished. As result, we cannot pay this claim. The patient is responsible for payment."

190.4.3 - Annual Update

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD -10, Implementation: ICD -10: Upon Implementation of ICD -10, ASC X12: September, 23 2014)

Prior to rate year (RY) 2012, the Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) was on a July 1st – June 30th annual update cycle. The first update to the IPF PPS occurred on July 1, 2006 and every July 1 thereafter.

Effective with RY 2012, the IPF PPS payment rate update period will switch from a rate year that begins on July 1st ending on June 30th to a period that coincides with a fiscal year (FY.) To transition from a RY to a

FY, the IPF PPS RY 2012 will cover the15 month period from July 1st – September 30th. This change to the payment update period will allow one consolidated annual update to both the rates and the *diagnosis and procedure* coding changes (MS-DRG and comorbidities). Coding and rate changes will continue to be effective October 1st – September 30th of each year thereafter.

In accordance with 42 CFR 412.428, the annual update includes revisions to the Federal per diem base rate, the hospital wage index, *diagnosis and procedure coding rules,* and Diagnosis-Related Groups (DRGs) classification changes discussed in the annual update to the hospital IPPS regulations, the electroconvulsive therapy (ECT) rate, the fixed dollar loss threshold amount and the national urban and rural cost-to-charge medians and ceilings.

Below are the Change Requests (CRs) for the applicable Rate Years (RYs) and Fiscal Years (FYs) which are issued via Recurring Update Notification.

RY 2009 - CR 6077
RY 2010 - CR 6461
RY 2011 - CR 6986
RY 2012 - CR 7367
FY 2013 - CR 8000
FY 2014 - CR 8395

Change Requests can be accessed through the following CMS Transmittals Web site:
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/Inpatient-Psychiatric-Facility-PPS-Transmittals.html

190.5.1 - Diagnosis- Related Groups (DRGs) Adjustments

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD -10, Implementation: ICD -10: Upon Implementation of ICD -10, ASC X12: September, 23 2014)

On claims with discharges before October 1, 2007, the IPF PPS provides adjustments for 15 designated DRGs. On claims with discharges on or after October 1, 2007, the IPF PPS provides adjustments for 17 designated MS-DRGs. Payment is made under the IPF PPS for claims with a principal diagnosis included in Chapter Five of the *International Classification of Diseases (*ICD-9- *or ICD-10 as applicable)* or the DSM-IV-TR. However, only those claims with diagnoses that group to a psychiatric DRG/MS-DRG will receive the DRG adjustment in addition to all other applicable adjustments. Although the IPF will not receive a DRG adjustment for a principal diagnosis not found in one of the following psychiatric DRGs/MS-DRGs, the IPF will receive the Federal per diem base rate and all other applicable adjustments.

IPFs must submit claims providing the principal diagnosis. To classify the case to the appropriate DRG/MS-DRG, the GROUPER software for the hospital IPPS is used and the IPF PRICER applies the appropriate adjustment factor to the Federal per diem base rate.

Changes to the ICD coding system are addressed annually in the IPPS proposed and final rules published each year. The updated codes are effective October 1 of each year and must be used to report diagnostic or procedure information

Since the IPF PPS uses the same GROUPER as the IPPS, including the same diagnostic code set and DRG classification system, the IPF PPS is adopting IPPS' new MS-DRG coding system in order to maintain that consistency. The updated codes are effective October 1 of each year. Although the code set is being updated, note that these are the same adjustment factors in place since implementation.

Based on changes to the IPPS, the following changes are being made to the principal diagnosis DRGs under the IPF PPS. Below is the crosswalk of current DRGs to the new MS-DRGs which were effective October 1, 2007:

(v24) DRG Prior to 10/01/07	(v25) MS-DRG From 10/01/07	MS-DRG Descriptions	Adjustment Factor
12	056 057	Degenerative nervous system disorders w MCC Degenerative nervous system disorders w/o MCC	1.05
023	080 081	Nontraumatic stupor & coma w MCC Nontraumatic stupor & coma w/o MCC	1.07
424	876	O.R. procedure w principal diagnoses of mental illness	1.22
425	880	Acute adjustment reaction & psychosocial dysfunction	1.05
426	881	Depressive neuroses	0.99
427	882	Neuroses except depressive	1.02
428	883	Disorders of personality & impulse control	1.02
429	884	Organic disturbances & mental retardation	1.03
430	885	Psychoses	1.00
431	886	Behavioral & developmental disorders	0.99
432	887	Other mental disorder diagnoses	0.92
433	894	Alcohol/drug abuse or dependence, left AMA	0.97
521-522	895	Alcohol/drug abuse or dependence w rehabilitation therapy	1.02
523	896 897	Alcohol/drug abuse or dependence w/o rehabilitation therapy w MCC Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MCC	0.88

190.5.2 - Application of Code First

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD -10, Implementation: ICD -10: Upon Implementation of ICD -10, ASC X12: September, 23 2014)

According to the ICD Official Guidelines for Coding and Reporting, when a principal diagnosis code has a Code First notation, the provider follows the applicable coding convention, which requires the underlying condition (etiology) to be sequenced first, followed by the manifestation due to the underlying condition. Therefore, CMS considers Code First diagnoses to be the principal diagnosis. The submitted claim goes through the IPF PPS claims processing system that identifies the principal diagnosis code as non-psychiatric and searches only the first "secondary" code for a psychiatric code to assign the DRG/MS-DRG in order to pay Code First claims properly.

For more coding guidance, refer to the ICD-9-CM Official Guidelines for Coding and Reporting which can be located on the *CDC* Web site at

http://www.cdc.gov/nchs/icd/icd9cm.htm

The ICD-10-CM Official Guidelines are posted on the CDC's website at

http://www.cdc.gov/nchs/icd/icd10cm.htm

The most current Code First list is posted on the IPF PPS Web site at

www.cms.hhs.gov/InpatientPsychFacilPPS . *Select Tools and Worksheets from the column at the left.*

Code First Example - ICD-9-CM

Diagnosis code 294.11 "Dementia in Conditions Classified Elsewhere with Behavioral Disturbances" is designated as "NOT ALLOWED AS PRINCIPAL DX" code.

Four digit code 294.1 "Dementia in Conditions Classified Elsewhere", is designated as a Code First diagnosis indicating that all 5 digit diagnosis codes that fall under the 294.1 category (codes 294.10 and 294.11) must follow the Code First rule. The 3 digit code 294 "Persistent Mental Disorders Due to Conditions Classified Elsewhere" appears in the ICD-9-CM as follows:

294 - PERSISTENT MENTAL DISORDERS DUE TO CONDITIONS CLASSIFIED ELSEWHERE

294.1 - Dementia in Conditions Classified Elsewhere

Code First any underlying physical condition, as:

Dementia in:

Alzheimer's disease (331.0)
Cerebral lipidosis (330.1)
Dementia with Lewy bodies (331.82)
Dementia with Parkinsonism (331.81)
Epilepsy (345.0 – 345.9)
Frontal dementia (331.19)
Frontotemporal dementia (331.19)
General paresis [syphilis] (094.1)
Hepatolenticular degeneration (275.1)
Huntington's chorea (333.4)
Jacob-Creutzfeldt disease (046.1)
Multiple sclerosis (340)
Pick's disease of the brain (331.11)
Polyarteritis nodosa (446.0)
Syphilis (094.1)

294.10 Dementia in Conditions Classified Elsewhere Without Behavioral Disturbances
NOT ALLOWED AS PRINCIPAL DX

294.11 Dementia in Conditions Classified Elsewhere With Behavioral Disturbances
NOT ALLOWED AS PRINCIPAL DX

According to Code First requirements, the provider would code the appropriate physical condition first, for example, 333.4 "Huntington's Chorea" as the principal diagnosis code and 294.11 "Dementia In Conditions Classified Elsewhere With Behavioral Disturbances" as a secondary diagnosis or comorbidity code on the patient claim.

The purpose of this example is to demonstrate proper coding for a Code First situation. However, in this case, the principal diagnosis groups to one of the 15 DRGs, or 17 MS-DRGs, for which CMS pays an adjustment. Had the diagnosis code grouped to a non-psychiatric DRG/MS-DRG, the PRICER would

search the first of the other diagnosis codes for a psychiatric code listed in the Code First list in order to assign a DRG adjustment.

Code First Example - ICD-10-CM

Diagnosis code F02.81 "Dementia in other diseases classified elsewhere with behavioral disturbance" is designated as "NOT ALLOWED AS PRINCIPAL DX" code.

The three digit code F02 "Dementia in other diseases classified elsewhere", is designated as a Code First diagnosis indicating that all diagnosis codes that fall under the F02 category (codes F02.80 and F02.81) must follow the Code First rule. The 3 digit code F02 "Dementia in other diseases classified elsewhere" appears in the ICD-10-CM as follows:

F02 Dementia in other diseases classified elsewhere
Code first the underlying physiological condition, such as:
Alzheimer's (G30.0 – G30.9)
cerebral lipidosis (E75.4)
Creutzfeldt-Jakob disease (A81.0 - A81.09)
dementia with Lewy bodies (G31.83)
epilepsy and recurrent seizures (G40 - G40.919)
frontotemporal dementia (G31.09)
hepatolenticular degeneration (E83.0)
human immunodeficiency virus [HIV] disease (B20)
hypercalcemia (E83.52)
hypothyroidism, acquired (E00 - E03.9)
intoxications (T36 - T65)
Jakob-Creutzfeldt disease (A81.00 - A81.09)
multiple sclerosis (G35)
neurosyphilis (A52.17)
niacin deficiency [pellagra] (E52)
Parkinson's disease (G20)
Pick's disease (G31.01)
polyarteritis nodosa (M30.0)
systemic lupus erythematosus (M32 - M32.9)
trypanosomiasis (B56 - B57.39)
vitamin B deficiency (E53.8)

F02.80 Dementia in other diseases classified elsewhere without behavioral disturbance
NOT ALLOWED AS PRINCIPAL DX

F02.81 Dementia in other diseases classified elsewhere with behavioral disturbance
NOT ALLOWED AS PRINCIPAL DX

According to Code First requirements, the provider would code the appropriate physical condition first, for example, G20 "Parkinson's disease" as the principal diagnosis code and F02.81 "Dementia in other diseases classified elsewhere with behavioral disturbance" as a secondary diagnosis or comorbidity code on the patient claim.

190.5.3 - Comorbidity Adjustments

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD -10, Implementation: ICD -10: Upon Implementation of ICD -10, ASC X12: September, 23 2014)

Comorbidities are specific patient conditions that are secondary to the patient's principal diagnosis and that require treatment during the stay. Diagnoses that relate to an earlier episode of care and have no bearing on the current hospital stay are excluded and not reported on IPF claims. Comorbid conditions must co-exist at

the time of admission, develop subsequently, affect the treatment received, affect the length of stay or affect both treatment and the length of stay. IPFs enter the full codes for up to twenty four additional diagnoses if they co-exist at the time of admission or develop subsequently.

The IPF PPS has 17 comorbidity categories, each containing codes of comorbid conditions. Each comorbidity grouping will receive a grouping-specific adjustment. Facilities can receive only one comorbidity adjustment per comorbidity category, but can receive an adjustment for more than one comorbidity category on the claim. The IPF PRICER then applies the appropriate adjustment factors to the Federal per diem base rate.

A list of the ICD-9-CM codes that are associated with each category is on the IPF PPS Web site at www.cms.hhs.gov/inpatientpsychfacilpps. *Select Tools and Worksheets from the column at the left.*

The 17 comorbidity categories and specific adjustments are as follows:

Description of Comorbidity	**Adjustment Factor**
Developmental Disabilities	1.04
Coagulation Factor Deficits	1.13
Tracheostomy	1.06
Renal Failure, Acute	1.11
Renal Failure, Chronic	1.11
Oncology Treatment	1.07
Uncontrolled Diabetes-Mellitus with or without complications	1.05
Severe Protein Calorie Malnutrition	1.13
Eating and Conduct Disorders	1.12
Infectious Disease	1.07
Drug and/or Alcohol Induced Mental Disorders	1.03
Cardiac Conditions	1.11
Gangrene	1.10
Chronic Obstructive Pulmonary Disease	1.12
Artificial Openings - Digestive and Urinary	1.08
Severe Musculoskeletal and Connective Tissue Diseases	1.09
Poisoning	1.11

190.6.4.1 - Source of Admission for IPF PPS Claims for Payment of ED Adjustment

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD -10, Implementation: ICD -10: Upon Implementation of ICD -10, ASC X12: September, 23 2014)

Source of admission code “D” is reported by IPFs to identify IPF patients who have been transferred to the IPF from the same hospital or CAH. Claims with source of admission code "D" do not receive the ED adjustment.

See Pub. 100-04, Medicare Claims Processing Manual chapter 25, §60.1, for additional instructions for completing the CMS *claim* data set.

190.7.3 - Electroconvulsive Therapy (ECT) Payment

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD -10, Implementation: ICD -10: Upon Implementation of ICD -10, ASC X12: September, 23 2014)

IPFs receive an additional payment for each ECT treatment furnished during the IPF stay. The ECT base rate is based on the median hospital cost used to calculate the calendar year 2005 Outpatient Prospective Payment System amount for ECT and is updated annually by the market basket and wage budget neutrality factor. The ECT base rate is adjusted by the wage index and any applicable COLA factor.

In order to receive the payment, an IPF must report revenue code 0901 along with the number of units of ECT on the claim. The units should reflect the number of ECT treatments provided to the patient during the IPF stay. In addition, IPFs must include the ICD-9-CM procedure code for ECT (94.27) in the procedure code field and use the date of the last ECT treatment the patient received during their IPF stay.

Effective with the implementation of ICD-10 the following ICD-10-PCS codes apply:

ICD-10-PCS Code and Description

GZB0ZZZ – Electroconvulsive Therapy, Unilateral-Single Seizure
GZB1ZZZ – Electroconvulsive Therapy, Unilateral-Multiple Seizure
GZB2ZZZ – Electroconvulsive Therapy, Bilateral-Single Seizure
GZB3ZZZ – Electroconvulsive Therapy, Bilateral-Muliple Seizure
GZB4ZZZ – OtherElectroconvulsive Therapy

It is important to note that since ECT treatment is a specialized procedure, not all providers are equipped to provide the treatment. Therefore, many patients who need ECT treatment during their IPF stay must be referred to other providers to receive the ECT treatments, and then return to the IPF. In accordance with 42 CFR 412.404(d)(3), in these cases where the IPF is not able to furnish necessary treatment directly, the IPF would furnish ECT under arrangements with another provider. While a patient is an inpatient of the IPF, the IPF is responsible for all services furnished, including those furnished under arrangements by another provider. As a result, the IPF claim for these cases should reflect the services furnished under arrangements by other providers.

190.10.1 - General Rules

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD -10, Implementation: ICD -10: Upon Implementation of ICD -10, ASC X12: September, 23 2014)

Effective with cost reporting periods beginning on or after January 1, 2005, the following claim preparation requirements apply to IPFs:

- Type of Bill (TOB) is 11X;
- Medicare provider number ranges for IPFs are from xx-4000 – xx-4499, xx-Sxxx, and xx-Mxxx; (**NOTE**: Implementation of NPI will change this.)
- The IPF must *correctly* code diagnoses for the principal diagnosis, and up to twenty four additional diagnoses, if applicable;
- The IPF must *correctly* code one principal procedure and up to twenty four additional procedures performed during the stay;
- The IPF must also code age, sex, and patient (discharge) status of the patient on the claim, using standard inpatient coding rules; and

- An IPF distinct part must code source of admission code "D" on incoming transfers from the acute care area of the same hospital to avoid overpayment of the emergency department adjustment when the acute area has billed or will be billing for covered services for the same inpatient admission.

Other general requirements for processing Medicare Part A inpatient claims described in Chapter 25 of this manual apply.

CMS' hospital inpatient GROUPER applicable to the discharge date (or effective December 3, 2007, benefits exhaust date, if present) on the claim will determine the DRG/MS-DRG assignment.

190.10.4 - Reporting ECT Treatments

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD -10, Implementation: ICD -10: Upon Implementation of ICD -10, ASC X12: September, 23 2014)

IPFs must report on their claims under Revenue Code 0901, along with the total number of ECT treatments provided to the patient during their IPF stay listed under “Service Units.” Providers will code ICD-9-CM procedure code 94.27 *if ICD-9-CM is applicable, or, effective with the implementation of ICD-10, the ICD-10-PCS codes listed below are reported* in the procedure code field, and for the procedure date will use the date of the last ECT treatment the patient received during their IPF stay.

ICD-10-PCS Code and Description

GZB0ZZZ – Electroconvulsive Therapy, Unilateral-Single Seizure
GZB1ZZZ – Electroconvulsive Therapy, Unilateral-Multiple Seizure
GZB2ZZZ – Electroconvulsive Therapy, Bilateral-Single Seizure
GZB3ZZZ – Electroconvulsive Therapy, Bilateral-Muliple Seizure
GZB4ZZZ – Other Electroconvulsive Therapy