CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-08 Medicare Program Integrity	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 585	**Date: April 3, 2015**
	Change Request 8937

SUBJECT: Coding Determinations

I. SUMMARY OF CHANGES: The purpose of this CR is to allow the Medicare Administrative Contractors (MACs), Supplemental Medical Review Contractor (SMRC), Comprehensive Error Rate Testing (CERT) contractor, Zone Program Integrity Contractors (ZPICs) and Recovery Auditors to not deny the entire claim when the medical record supports a higher or lower level code, but instead shall adjust the code and adjust the payment. The MACs, SMRC, ZPICs, CERT and Recovery Auditors shall up code or down code when it is possible to pay for the item or service actually provided without making a reasonable and necessary determination or if otherwise specified in applicable CMS medical review instructions. The MACs, SMRC, ZPICs, CERT and Recovery Auditors shall not substitute the payment amount of one item or service for a different item or service based on a reasonable and necessary determination.

EFFECTIVE DATE: May 4 2015
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: May 4, 2015

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	3/3.6.2.4/Coding Determinations

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

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

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I. GENERAL INFORMATION

A. Background: In certain situations, it is appropriate for contractors to up code or down code a claim (or items or services on a claim) and adjust the payment.

B. Policy: When the medical record supports a higher or lower level code, the Medicare Administrative Contractors (MACs), Supplemental Medical Review Contractor (SMRC), Comprehensive Error Rate Testing (CERT) contractor, Zone Program Integrity Contractors (ZPICs) and Recovery Auditors shall not deny the entire claim but instead shall adjust the code and adjust the payment. The MACs, SMRC, ZPICs, CERT and Recovery Auditors shall up code or down code when it is possible to pay for the item or service actually provided without making a reasonable and necessary determination or if otherwise specified in applicable CMS medical review instructions. The MACs, SMRC, ZPICs, CERT and Recovery Auditors shall not substitute the payment amount of one item or service for a different item or service based on a reasonable and necessary determination.

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	
8937.1	The MACs, CERT, SMRC, Recovery Auditors, and ZPICs shall determine that an item/service is correctly coded when it meets all the coding guidelines listed in the Current Procedural Terminology-4 (CPT-4), Coding Clinic for ICD-9, Coding Clinic for HCPCS, and any coding requirements listed in CMS manuals or MAC articles.	X	X	X	X					CERT, RACs, SMRC, ZPICs
8937.2	When the medical record supports a higher or lower level code, the MACs, SMRC, CERT, ZPICs and Recovery Auditors shall not deny the entire claim but instead shall adjust the code and adjust the payment.	X	X	X	X					CERT, RACs, SMRC, ZPICs
8937.2.1	The MACs, SMRC, CERT, ZPICs and Recovery Auditors shall up code or down code when it is possible to pay for the item or service actually provided without making a reasonable and necessary determination or if otherwise specified in applicable	X	X	X	X					CERT, SMRC, ZPICs

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	CMS medical review instructions.									
8937.2.2	The MACs, SMRC, CERT, ZPICs and Recovery Auditors shall not substitute the payment amount of one item or service for a different item or service based on a reasonable and necessary determination.	X	X	X	X					CERT, RACs, SMRC, ZPICs

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): Marissa Malcolm, marissa.malcolm@cms.hhs.gov, Jennifer McCormick, Jennifer.McCormick1@cms.hhs.gov

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

3.6.2.4 - Coding Determinations

(Rev.585, Issued: 04- 03-15: Effective: 05-04-15, Implementation: 05- 04-15)

This section applies to MACs, CERT, *SMRC,* Recovery Auditors, and ZPICs, as indicated.

Use ICD-9 until such time as ICD-10 is in effect. Further instructions will be issued regarding claims containing ICD-9 codes with dates of service prior to the ICD-10 implementation that are submitted after ICD-10 is in effect.

The MACs, CERT, *SMRC,* Recovery Auditors, and ZPICs shall determine that an item/service is correctly coded when it meets all the coding guidelines listed in the Current Procedural Terminology-4 (CPT-4), Coding Clinic for ICD-9, Coding Clinic for HCPCS, and any coding requirements listed in CMS manuals or MAC articles.

In certain situations, it is appropriate for contractors to up code or down code a claim (or items or services on a claim) and adjust the payment. When the medical record supports a higher or lower level code, the MACs, SMRC, CERT, ZPICs and Recovery Auditors shall not deny the entire claim but instead shall adjust the code and adjust the payment. The MACs, SMRC, CERT, ZPICs and Recovery Auditors shall up code or down code when it is possible to pay for the item or service actually provided without making a reasonable and necessary determination or if otherwise specified in applicable CMS medical review instructions. The MACs, SMRC, CERT, ZPICs and Recovery Auditors shall not substitute the payment amount of one item or service for a different item or service based on a reasonable and necessary determination.

Example situations where it is appropriate to up code or down code a claim are:

1. *CBC with diff was ordered and billed but CBC without diff was provided;*
2. *X-ray with contrast was ordered and billed but X-ray without contrast was provided;*
3. *E&M level 3 was billed but the medical record supports level 2 (or other level);*
4. *PPS (DRG/RUG/HHRG) code was billed but the medical records supports a different code; and*
5. *Quantity of diabetic test strips exceeds limits; for example, quantity was provided for insulin treated but the patient was not insulin treated.*