



Related MLN Matters Article #: MM3949

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### *MMA – Billing and Claims Processing Instructions for Claims Subject to Expedited Determinations*

#### Key Words

Billing, Determination, QIO, QIC, CORF, HHA, MM3949, CR3949, R632CP, CR3903, MMA

#### Provider Types Affected

Hospitals, Skilled Nursing Facilities (SNFs), Home Health Agencies (HHAs), Hospices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs) billing services to Medicare intermediaries, including Regional Home Health Intermediaries (RHHIs)

#### Key Points

- The instructions in MLN Matters article MM3949 and related Change Request (CR) 3949 apply to claims submitted on or after January 3, 2006, with dates of service on or after July 1, 2005.
- The implementation date is January 3, 2006.
- The Centers for Medicare & Medicaid Services (CMS) published preliminary instructions on the expedited determinations process in CR3903 in response to the amendment of the Benefits Improvement and Protection Act (BIPA) by the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) requiring an expedited determination process.
- CR3903, dated June 24, 2005, provided only the billing changes to reflect the outcomes of expedited review, which could be accepted without changes to current Medicare systems.
- CR3949 completes the preliminary instructions and provides:
  - Billing instructions to accommodate full reporting of expedited review outcomes on claims; and
  - Requirements for systems changes to accept the indicators that reflect those outcomes.

## Claim Indicators

- The claim indicators regarding expedited review outcomes that will enable intermediaries to be aware of Quality Improvement Organization (QIO)/Qualified Independent Contractors (QIC) determinations when developing claims for medical review and other reasons are as follows:
  - **Condition Code C3:** Partial Approval (The claim was reviewed by the QIO, and some days of the stay or services were denied; the Occurrence Span Code M0 indicates the dates of service for the stay that were approved.)
  - **Condition Code C4:** Services Denied (The claim was reviewed by the QIO, and all services beyond the intended discharge date were denied.)
  - **Condition Code C7:** Extended Authorization (QIO authorization for services extended.)
  - **Occurrence Span Code M0:** QIO/UR approved stay dates.

## Claims Submitted On or After January 3, 2006

- Providers should follow the billing requirements below for claims submitted **on or after January 3, 2006**:
  - Report Condition Code C4 on original claims and provider-submitted adjustments with dates of service on or after July 1, 2005, to reflect QIO/QIC determinations upholding discharge.
  - Report Condition Code C4 on original claims and adjustments with types of bill (TOBs) 18x, 21x, 22x, 32x, 33x, 34x, 75x, 81x, or 82x.
  - Report Occurrence Span Code 76, denoting "patient liability period," in cases where the beneficiary may be liable for payment and where Condition Code C4 applies.
  - The Medicare intermediary will return the provider's claim or adjustment containing Condition Code C4 if the patient Status Code is 30 unless Condition Code 20 or Occurrence Code 31 or 32 is also present on the claim.
  - Report Condition Codes C3 or C7, to reflect QIO/QIC determinations reversing a discharge, but note the following:
    - Report Condition Codes C3 or C7 on original claims and provider-submitted adjustments with dates of service on or after July 1, 2005.
    - When appropriate, report Condition Codes C3 or C7 on original claims adjustments with TOBs 18x, 21x, 22x, 32x, 33x, 34x, 75x, 81x, or 82x.
    - The Medicare intermediary will return the provider's claims or adjustments that report Condition Code C3 if Occurrence Span Code M0 is not also present.

## Important Links

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3949.pdf>

For complete details, affected providers should see the official instruction issued to their fiscal intermediary at <http://cms.hhs.gov/transmittals/downloads/R632CP.pdf> on the CMS web site.

The official instruction issued for CR3903 may be found at <http://www.cms.hhs.gov/Transmittals/downloads/R594CP.pdf> on the CMS web site.

If affected providers have any questions, they should contact their intermediary at their toll-free number, which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS web site.