



## Processing of Non-Covered International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) Procedure Codes on Inpatient Hospital Claims – JA6547

**Note:** MLN Matters® article was revised to reflect a revised Change Request (CR) 6547 that was issued on January 15, 2010. In the article, the CR release date, transmittal numbers (see below), and the Web addresses for accessing the transmittals were changed. All other information remains the same.

Related CR Release Date: January 15, 2010 **Revised**

Date Job Aid Revised: January 21, 2010

Effective Date: April 1, 2010

Implementation Date: April 5, 2010

**Key Words** MM6547, CR6547, R1895CP, ICD-9-CM, Inpatient, Hospital

**Contractors Affected**

- Fiscal Intermediaries (FIs)
- Part A/B Medicare Administrative Contractors (MACs)

**Provider Types Affected** Hospitals submitting claims to A/B MACs or FIs for procedures performed for Medicare beneficiaries are affected.



- Effective for inpatient discharges on or after April 1, 2010, hospitals must submit ICD-9-CM codes for non-covered procedures performed in the same inpatient stay with covered procedures on a separate claim.
- CR6547 provides instructions to Medicare contractors for processing these claims for non-covered services, also referred to as no-pay claims.

**Provider Needs to Know...**

- Effective for inpatient discharges on or after April 1, 2010, hospitals must separate a hospital stay into two claims where both covered and non-covered ICD-9-CM procedure codes are reported:
  - One claim with covered services/procedures unrelated to the non-covered ICD-9-CM procedures on a Type of Bill (TOB) 11X (with the exception of TOB 110); and
  - The other claim with the non-covered services/procedures on a TOB 110 (no-pay)

claim).

- The Statement Covers Period should match on both the covered and the non-covered claim.
- No-pay claims submitted will be denied as non-covered, using the following on the remittance advice:
  - **Claim Adjustment Reason Code:**  
50 – "These are non-covered services because this is not deemed a 'medical necessity' by the payer."
  - **Group Code used when a Hospital Issued Notice of Non-Coverage (HINN) was not issued:**  
CO – Contractual Obligation
  - **Group Code used when a HINN was issued:**  
PR- Patient Responsibility.

**Background**

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

**Operational Impact**

N/A

**Reference Materials**

The related MLN Matters® article can be found at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6547.pdf> on the CMS website.

The official instruction (CR6547) issued regarding this change may be found at <http://www.cms.hhs.gov/Transmittals/downloads/R1895CP.pdf> on the CMS website.